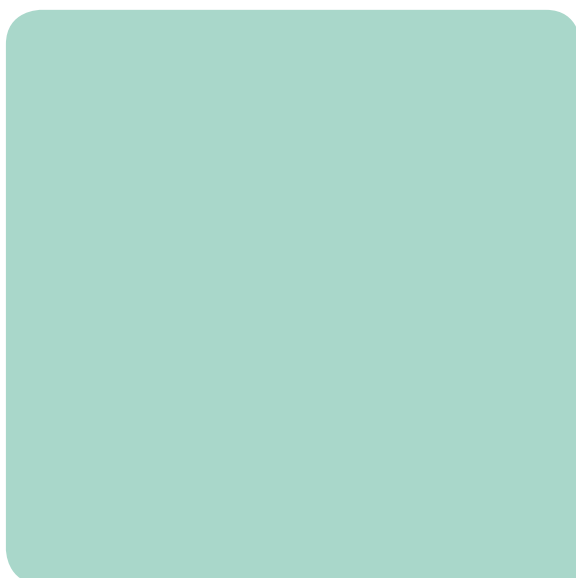


# Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse



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Produced by the Social Care Institute for Excellence with the  
Pan London Adult Safeguarding Editorial Board

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## Local information

This page is for local adult safeguarding boards to add information and contacts about how this document will be implemented locally.

## Foreword

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

And when abuse does take place, it needs to be dealt with swiftly, effectively and in ways which are proportionate to the issues and where the adult in need of protection stays as much in control of the decision making as is possible. The rights of the individual to be heard throughout this process are a critical element of the drive towards more personalised care and support.

In London, as elsewhere, the main statutory agencies – local councils, the police and NHS organisations – need to work together **both** to promote safer communities to prevent harm and abuse **and** also to deal well with suspected or actual cases. That is why we have come together to produce this document on *Protecting adults at risk: London multi-agency policy and procedures*. It is our firm belief that adults at risk are best protected when procedures between statutory agencies are consistent across London.

All staff, in whatever setting and role, are in the front line in preventing harm or abuse occurring and in taking action where 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 adults at risk. The target audience is professionals (including unqualified staff and volunteers) and front-line workers.

Protection, Prevention, Partnership and Personalisation are not just the building blocks of a 'Big Society', they are the corner stones to protecting adults at risk of harm.

Much progress has already been made. However, much more remains to be done. Our aim is to consolidate our experience to date and to encourage the development of work in order to better protect adults at risk throughout London. This should therefore be seen as a 'living' document which will be updated regularly as both practice and policy develop.

Comments and suggestions about this document should be directed to the Social Care Institute for Excellence, Goldings House, 2 Hay's Lane, London, SE1 2HB ([www.scie.org.uk](http://www.scie.org.uk)).

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Association of Directors of Adult Social Services ([www.adass.org.uk](http://www.adass.org.uk))

City of London Police ([www.cityoflondon.police.uk](http://www.cityoflondon.police.uk))

London Ambulance Service ([www.londonambulance.nhs.uk](http://www.londonambulance.nhs.uk))

London Councils ([www.londoncouncils.gov.uk](http://www.londoncouncils.gov.uk))

London Fire Brigade ([www.london-fire.gov.uk](http://www.london-fire.gov.uk))

Metropolitan Police Service ([www.met.police.uk](http://www.met.police.uk))

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## Glossary and acronyms

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

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

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

**Adult at risk** means adults who need community care services because of mental or other disability, age or illness and who are, or may be unable, to take care of themselves against significant harm or exploitation. The term replaces 'vulnerable adult'.

**Advocacy** is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

**Alert** is a concern that an adult at risk is or may be a victim of abuse or neglect. An alert may be a result of a disclosure, an incident, or other signs or indicators.

**Alerter** is the person who raises a concern that an adult is being, has been, or is at risk of being abused or neglected. This could be the person themselves, a member of their family, a carer, a friend or neighbour or could be a member of staff or a volunteer.

**Alerting manager** is the person within an organisation to whom the alerter is expected to report their concerns. They may also be the designated Safeguarding Adults lead within an organisation. It is the alerting manager who will in most cases make the referral and take part in the Safeguarding Adults process.

**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).

**CAD (computer-aided despatch)** is the Metropolitan Police Service's (MPS) call-handling system. The operator can also call up details of the nearest police units available to respond and view lists of assigned and unassigned calls for all boroughs.

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

**Care setting/services** includes health care, nursing care, social care, domiciliary care, social activities, support setting, emotional support, housing support, emergency housing, befriending and advice services *and* services provided in someone's own

home by an organisation or paid employee for a person by means of a personal budget.

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

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

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

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

**CMHTs (community mental health teams)** are made up of a team of professionals and support staff who provide specialist mental health services to people within their community.

**Consent** is the voluntary and continuing permission of the person to the intervention based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it.

**CPA (Care Programme Approach)** was introduced in England in the joint Health and Social Services Circular HC(90)23/LASSL(90)11, 'The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services', published by the Department of Health in 1990. This requires health authorities, in collaboration with social services departments, to put in place specified arrangements for the care and treatment of people with mental ill health in the community.

**CPS (Crown Prosecution Service)** is the government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

**CQC (Care Quality Commission)** is responsible for the registration and regulation of health and social care in England.

**CRIS (Crime Recording Information System)** is the Metropolitan Police Service (MPS) database which allows police officers to input details of crimes directly into it and to conduct online searches of the data.

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

**DASH (Domestic Abuse, Stalking and Harassment and 'Honour'-based violence)** risk identification checklist (RIC) is a tool used to help front-line practitioners identify high-risk cases of domestic abuse, stalking and 'honour'-based violence.

**DoLS (Deprivation of Liberty Safeguards)** are measures to protect people who lack the mental capacity to make certain decisions for themselves. They came into effect in April 2009 using the principles of the Mental Capacity Act 2005, and apply to people in care homes or hospitals where they may be deprived of their liberty.

**EDO (emergency duty officer)** is the social worker on duty in the emergency duty team (EDT).

**EDT (emergency duty teams)** are social services teams that respond to out-of-hours referrals where intervention from the council is required to protect a vulnerable child or adult, and where it would not be safe, appropriate or lawful to delay that intervention to the next working day.

**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 to gather evidence to determine whether abuse took place.

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

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

**Jigsaw** is the name of the Metropolitan Police Service (MPS) team that deals with the management of sexual and violent offenders who come within the Multi-agency Public Protection Arrangements (MAPPA).

**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.

**MPS (Metropolitan Police Service)** is the police force responsible for policing Greater London, excluding the 'square mile' of the City of London, which is the responsibility of the City of London Police.

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

**OASys (Offender Assessment System)**, a standardised process for the assessment of offenders, developed jointly by the National Probation Service and the Prison Service.

**OIC (officer in charge)** is the police officer responsible for an investigation.

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

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

**Person causing the harm** is the person or adult who is alleged to have caused the abuse or harm.

**Public interest** – a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

**QIPP (quality, innovation, productivity and prevention)** is a Department of Health initiative to help NHS organisations to deliver sustainable services in better, more cost-efficient ways.

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

**RIC (risk identification checklist)**, please see DASH above.

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

**Safeguarding Adults coordinator** – this is the typical title of the manager in a local authority who supports the work of the Safeguarding Adults Partnership Board (SAPB) and advises on Safeguarding Adults cases in the borough. The role varies from borough to borough, and may have a different title.

**Safeguarding Adults lead** is the title given to the member of staff in an organisation who is given the lead for Safeguarding Adults. The role may be combined with that of alerting manager, depending on the size of the organisation.

**SAMs (Safeguarding Adults managers)** are professionals or managers (usually in a social work or community mental health team [CMHT]) suitably qualified and experienced who have received Safeguarding Adults training. SAMs are responsible for coordinating all Safeguarding Adults activity by organisations in response to an allegation of abuse.

**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.

**SAPB (Safeguarding Adults Partnership Board)** represents various organisations in a local borough who are involved in safeguarding adults.

**Sapphire Units (Police)** – each borough has a dedicated Sapphire Unit that has specially trained officers to investigate rape and to look after victims, ensuring they are provided with the information they need, including the details for any partner agencies, and kept up to date with any developments.

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

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

**SI (Serious Incident)** is a term used by the National Patient Safety Agency (NPSA) in its national framework for serious incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

**Significant harm** is not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable

deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development.

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

**Strategy discussion** is a multi-agency discussion between relevant organisations involved with the adult at risk to agree how to proceed with the referral. It can be face to face, by telephone or by email.

**Strategy meeting** is a multi-agency meeting with the relevant individuals involved, and with the adult at risk where appropriate, to agree how to proceed with the referral.

**Vital interest** is a term used in the Data Protection Act 1998 to permit sharing of information where it is critical to prevent serious harm or distress or in life-threatening situations.

**Wilful neglect** is an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves.

## Introduction

### Aims

*Protecting adults at risk* represents the commitment of organisations in Greater London to work together to safeguard adults at risk. The procedures aim to make sure that:

- the needs and interests of adults at risk are always respected and upheld
- the human rights of adults at risk are respected and upheld
- a proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse
- all decisions and actions are taken in line with the Mental Capacity Act 2005.

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

- choice and control
- safety
- health
- quality of life
- dignity and respect.

### Working together

The policy and procedures are for different agencies and individuals involved in safeguarding adults, including managers, professionals, volunteers and staff working in public, voluntary and private sector organisations. They represent the commitment of organisations to:

- work together to prevent and protect adults at risk from abuse
- empower and support people to make their own choices
- investigate actual or suspected abuse and neglect
- support adults and provide a service to adults at risk who are experiencing abuse, neglect and exploitation.

According to the *No secrets* government guidance (DH, 2000), local authorities have the lead role in coordinating work to safeguard adults. However, the guidance recognises that successful responses need multi-agency and multi-disciplinary working.

### Local implementation

Each local partnership is asked to adopt this policy and procedures so that there is consistency across London in how adults at risk are safeguarded from abuse. However, some local partnerships may want to adapt some aspects of the procedures to meet their local arrangements. For example, some boroughs may have a slightly different approach to thresholds for Safeguarding Adults action. Local partnerships could add an appendix to this policy and procedures, outlining any variations.



Individual organisations may also wish to have internal guidelines for their staff. Again, organisations are encouraged to adopt these procedures as their main guidance, but to add an appendix outlining internal arrangements such as contact details.

These procedures should also be used in conjunction with partnerships' and individual organisations' procedures on related issues such as domestic violence, fraud, disciplinary procedures and health and safety.

## Structure of the report

The priority of the organisations involved in developing this report was taking action to safeguard adults. This report is therefore in two main parts: policy and procedures. The first part outlines the policy underpinning the procedures, including detailed definitions and information on related processes. The second part outlines the procedures to respond to suspected or actual abuse of an adult at risk.

## Review

The procedures outlined here are seen as one stage in an ongoing process to improve the London-wide response to abuse of adults at risk. They will be constantly reviewed and revised to further improve this response.

# 1 Policy

## 1.1 Principles and values

### 1.1.1 Statements and key principles

#### 1.1.1.1 Adults at risk

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

#### 1.1.1.2 Organisations working with adults at risk

- Staff have a duty to report in a timely way any concerns or suspicions that an adult at risk is being or is at risk of being abused
- Actions to protect the adult from abuse should always be given high priority by all organisations involved. Concerns or allegations should be reported without delay and given high priority
- Organisations working to safeguard adults at risk should make the dignity, safety and well-being of the individual a priority in their actions
- As far as possible organisations must respect the rights of the person causing harm. If that person is also an adult at risk they must receive support and their needs must be addressed
- Staff will understand their role and responsibilities in regard to this policy and procedures
- Every effort should be made to ensure that adults at risk are afforded appropriate protection under the law
- Organisations will have their own internal operational procedures which relate to these multi-agency Safeguarding Adults policy and procedures, including complaints, and in respect of support to staff who raise concerns ('whistleblowing') to comply with the Public Interest Disclosure Act 1998.
- Organisations will ensure that all staff and volunteers are familiar with policies relating to Safeguarding Adults, know how to recognise abuse and how to report and respond to it.
- Organisations will ensure that staff and volunteers will have access to training that is appropriate to their level of responsibility and will receive clinical and/or

management supervision that affords them the opportunity to reflect on their practice and the impact of their actions on others.

### 1.1.1.3 Organisations working together in Safeguarding Adults

- Partner organisations will contribute to effective inter-agency working and effective multi-disciplinary assessments and joint working partnerships in order to provide the most effective means of safeguarding adults.
- Action taken under these procedures does not affect the obligations on partner organisations to comply with their statutory responsibilities such as notification to regulatory authorities under the Health and Social Care Act 2008 or to comply with employment legislation
- Organisations continue to have a duty of care to adults who purchase their own care through personal budgets and are required to ensure that reasonable care is taken to avoid acts or omissions that are likely to cause harm to the adult at risk
- Partner organisations will have information about individuals who may be at risk from abuse and may be asked to share this where appropriate, with due regard to confidentiality.

## 1.2 Adult(s) at risk and adult abuse

### 1.2.1 Definition of an adult at risk

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

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

An adult aged 18 years or over 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation' (DH, 2000). This definition is taken from the current Department of Health guidance to local partnerships. Other definitions exist in partner organisations. An adult at risk *may* therefore be a person who:

- is elderly and frail due to ill health, physical disability or cognitive impairment
- has a learning disability
- has a physical disability and/or a sensory impairment
- has mental health needs including dementia or a personality disorder
- has a long-term illness/condition
- misuses substances or alcohol
- is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse
- is unable to demonstrate the capacity to make a decision and is in need of care and support

(This list is not exhaustive.)

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

An adult at risk's vulnerability is determined by a range of interconnected factors including personal characteristics, factors associated with their situation or environment and social factors. Some of these are described below, in Table 1.1.

**Table 1.1: Factors determining vulnerability**

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

### 1.2.2 Mental capacity

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

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

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

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

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

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

Mental capacity is time- and decision-specific. This means that a person may be able to make some decisions but not others at a particular point in time. For example, a person may have the capacity to consent to simple medical examination but not to major surgery. Their ability to make a decision may also fluctuate over time.

#### 1.2.2.1 Principles of the Mental Capacity Act 2005

- An adult at risk has the right to make their own decisions and must be assumed to have capacity to make decisions about their own safety unless it is proved (on a balance of probabilities) otherwise
- Adults at risk must receive all appropriate help and support to make decisions before anyone concludes that they cannot make their own decisions
- Adults at risk have the right to make decisions that others might regard as being unwise or eccentric and a person cannot be treated as lacking capacity for these reasons

- Decisions made on behalf of a person who lacks mental capacity must be done in their best interests and should be the least restrictive of their basic rights and freedoms.

#### 1.2.2.2 Ill treatment and wilful neglect

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

#### 1.2.3 Consent

It is always essential in safeguarding to consider whether the adult at risk is capable of giving informed consent. If they are, their consent should be sought. This may be in relation to whether they give consent to:

- an activity that may be abusive – if consent to abuse or neglect was given under duress, for example, as a result of exploitation, pressure, fear or intimidation, this apparent consent should be disregarded
- a Safeguarding Adults investigation going ahead in response to a concern that has been raised. Where an adult at risk with capacity has made a decision that they do not want action to be taken and there are no public interest or vital interest considerations, their wishes must be respected. The person must be given information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the short and long term
- the recommendations of an individual protection plan being put in place
- a medical examination
- an interview
- certain decisions and actions taken during the Safeguarding Adults process with the person or with people who know about their abuse and its impact on the adult at risk.

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

- there is a public interest, for example, not acting will put other adults or children at risk
- there is a duty of care to intervene, for example, a crime has been or may be committed.

#### 1.2.4 Abuse

For the purpose of the Safeguarding Adults policy and procedures the term *abuse* is defined as:

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

Abuse may be:

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

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

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

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

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

#### **1.2.4.1 Significant harm**

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

- ill treatment (including sexual abuse and forms of ill treatment which are not physical)
- the impairment of, or an avoidable deterioration in, physical or mental health and/or
- the impairment of physical, intellectual, emotional, social or behavioural development.

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

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

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

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

Abuse can be viewed in terms of the following categories:

- physical
- sexual
- psychological/emotional
- financial and material
- neglect and acts of omission
- discriminatory
- institutional.

Many abusive behaviours may constitute a criminal offence. All suspected abuse must be investigated (see Stage Two: Making a referral in Section 2).

#### **1.2.4.2 Physical abuse**

Examples of physical assault are hitting, pushing, pinching, shaking, misusing medication, scalding, the misuse or illegal use of restraint, inappropriate sanctions, exposure to heat or cold and not giving adequate food or drink.

#### **Restraint**

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

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



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

#### **1.2.4.3 Sexual abuse**

Rape and other sexual assaults are among the most serious offences investigated by the Metropolitan Police Service (MPS). The trauma that victims suffer presents unique challenges to any investigation. It is incumbent on all staff to ensure that they are aware of the standards set out in this policy and procedures document and to ensure confidence of achieving the best possible response to the adult at risk. Staff should also make reference to any additional policies held by their organisation.

All staff should be aware of their individual roles and responsibilities to maximise all evidential opportunities to assist any investigation of a sexual nature and the minimum standards required regarding immediate response, recording and reporting.

Some examples of sexual abuse/assault include the direct or indirect involvement of the adult at risk in sexual activity or relationships which:

- they do not want or have not consented to
- they cannot understand and lack the mental capacity to be able to give consent to
- they have been coerced into because the other person is in a position of trust, power or authority, for example, a care worker.

They may have been forced into sexual activity with someone else or may have been required to watch sexual activity.

#### **1.2.4.4 Key principles**

- The most important priority is to ensure that the urgent medical and welfare requirements of the adult at risk are met
- Preserve any potential forensic opportunities, and record verbatim the disclosure made by the adult at risk
- Any sexual activity that is not freely consented to is criminal and must be reported immediately to the police via 999, before any internal investigation/ interview
- Sexual relationships or inappropriate sexual behaviour between a member of staff and a service user are always abusive and will lead to disciplinary proceedings. This is additional to any criminal action that has been taken
- A sexual relationship between the service user and a care worker is a criminal offence under Sections 38–42 of the Sexual Offences Act 2003
- The MPS has specialised units called Sapphire Units ([www.met.police.uk/sapphire](http://www.met.police.uk/sapphire)) that investigate rape and serious sexual assaults. A specially trained officer will be responsible for arranging a forensic examination. This will normally be conducted at a sexual assault referral centre (The Havens, see [www.thehavens.co.uk](http://www.thehavens.co.uk)). However, if it is not appropriate for a client to be taken by police to The

Havens, the officer will make arrangements for the examination to be facilitated elsewhere.

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

#### **1.2.4.5 Psychological/emotional abuse**

This is behaviour that has a harmful effect on the person's emotional health and development or any form of mental cruelty that results in:

- mental distress
- the denial of basic human and civil rights such as self-expression, privacy and dignity
- negating the right of the adult at risk to make choices and undermining their self-esteem
- isolation and over-dependence that has a harmful effect on the person's emotional health, development or well-being.

It is the wilful infliction of mental suffering by a person who is in a position of trust and power to an adult at risk. Psychological/emotional abuse results from threats of harm or abandonment, being deprived of social or any other sort of contact, humiliation, blaming, controlling, intimidation, coercion and bullying. It undermines the adult's self-esteem and results in them being less able to protect themselves and exercise choice. It is a type of abuse that can result from other forms of abuse and often occurs at the same time as other types of abusive behaviour.

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

#### **1.2.4.6 Financial abuse**

Financial abuse is a crime. It is the use of a person's property, assets, income, funds or any resources without their informed consent or authorisation. It includes:

- theft
- fraud
- exploitation
- undue pressure in connection with wills, property, inheritance or financial transactions
- the misuse or misappropriation of property, possessions or benefits
- the misuse of an enduring power of attorney or a lasting power of attorney, or appointeeship.

#### **1.2.4.7 Neglect and acts of omission**

Neglect is the failure of any person who has responsibility for the charge, care or custody of an adult at risk to provide the amount and type of care that a reasonable person would be expected to provide.

Behaviour that can lead to neglect includes including ignoring medical or physical needs, failing to allow access to appropriate health, social care and educational services, and withholding the necessities of life such as medication, adequate nutrition, hydration or heating.

Neglect can be intentional or unintentional. Intentional neglect would result from:

- wilfully failing to provide care
- wilfully preventing the adult at risk from getting the care they needed
- being reckless about the consequences of the person not getting the care they need.

If the individual committing the neglect is aware of the consequences and the potential for harm to result due to the lack of action(s) then the neglect is intentional in nature.

Unintentional neglect could result from a carer failing to meet the needs of the adult at risk because they do not understand the needs of the adult at risk, may not know about services that are available or because their own needs prevent them from being able to give the care the person needs. It may also occur if the individuals are unaware of or do not understand the possible effect of the lack of action on the adult at risk.

#### **1.2.4.8 Discriminatory abuse**

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

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

#### **1.2.4.9 Institutional abuse**

Institutional abuse is the mistreatment or abuse or neglect of an adult at risk by a regime or individuals within settings and services that adults at risk live in or use, that violate the person's dignity, resulting in lack of respect for their human rights.

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.

Institutional abuse can occur in any setting providing health and social care. A number of inquiries into care in residential settings have highlighted that institutional abuse is most likely to occur when staff:

- receive little support from management
- are inadequately trained
- are poorly supervised and poorly supported in their work
- receive inadequate guidance.

The risk of abuse is also greater in institutions:

- with poor management
- with too few staff
- which use rigid routines and inflexible practices
- which do not use person-centred care plans
- where there is a closed culture.

#### **1.2.4.10 Deprivation of Liberty Safeguards (DoLS)**

DoLS apply to people who have a mental disorder and who do not have mental capacity to decide whether or not they should be accommodated in the relevant care home or hospital to be given care or treatment.

These safeguards provide protection to people in hospitals and care homes. Care homes must make requests to a local authority for authorisation to deprive someone of their liberty if they believe it is in their best interest. Hospitals must make requests to the primary care trust (PCT). All decisions on care and treatment must comply with the Mental Capacity Act and the Mental Capacity Act Code.

The Care Quality Commission (CQC) has also issued guidance for providers of registered care and treatment services on DoLS.

Reference should be made to the relevant local authority and health trust for procedures relating to DoLS.

### **1.2.5 Related issues**

#### **1.2.5.1 Self-neglect**

Self-neglect does not come under the scope of these procedures – which relate to circumstances where there is a person or agent, other than the adult at risk, who is causing significant harm. Practitioners should refer to other procedures relating to handling self-neglect.

### **1.2.5.2 Hate crime**

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

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

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

The police and other organisations should work together to intervene under Safeguarding Adults policy and procedures to ensure a robust, coordinated and timely response to situations where adults at risk become a target for hate crime. Coordinated action will aim to ensure that victims are offered support and protection, and action is taken to identify and prosecute those responsible. Hate crimes are one of the categories of crime investigated by borough Community Safety Units (CSUs). In the MPS there are 32 such units (one for each local authority). The CSUs have specialist hate crime investigators to ensure that victims are fully supported.

Anyone can be a victim of abuse regardless of sexuality or gender. However lesbian, gay, bisexual and transgender (LGBT) individuals could face additional concerns around homophobia and gender discrimination. There may be concern that individuals would not be recognised as victims or be believed and taken seriously. Abusers may also control their victims, threatening to 'out' them to friends, family or support agencies. Professionals may need to seek advice from LGBT organisations to assist in the support of victims.

### **Abuse in domestic settings**

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

Whatever form it takes, domestic abuse is rarely a one-off incident and should instead be seen as a pattern of abusive and controlling behaviour through which the abuser seeks power over the victim. Domestic abuse occurs across society, regardless of age, gender, 'race', sexuality, wealth and geography. The figures show, however, that it consists mainly of violence by men against women. Children are also affected both directly and indirectly and there is also a strong correlation between domestic violence and child abuse.

Approximately one in five homicides in London are domestic related, with the murder of a parent by a son being prevalent. Therefore, it is important that all agencies are as robust in their interventions with interfamilial domestic violence as they are with intimate/ex-partner relationships and appropriate support services are sought to meet the needs of the adult who is experiencing domestic violence.

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

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

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

The four aims of a MARAC are as follows:

- to safeguard adult victims who are at high risk of future domestic violence
- to make links with other public protection arrangements in relation to children, people causing harm and vulnerable adults
- to safeguard agency staff and
- to work towards addressing and managing the behaviour of the person causing harm.

After sharing all relevant information that they have about an adult at risk, the representatives discuss options for increasing the safety of the adult at risk and form a coordinated action plan. The MARAC will also discuss the risks posed to children and how to manage the person alleged to be causing the harm. At the heart of a MARAC is a working assumption that no single agency or individual can see the complete picture of the life of a person at risk, but all may have insights that are crucial to their safety, as part of the coordinated community response to domestic violence.

The person at risk does not attend the meeting but is represented by an IDVA. Good practice indicates that all victims that are referred to the MARAC should also be referred to an IDVA. The role of the IDVA is to provide an independent domestic violence support service and advocate on their behalf at the MARAC meeting.

The MARAC will seek better protection for those who disclose domestic abuse and are at highest risk of being injured or killed. Referrals will be made through the local MARAC coordinator, who will also be able to advise on the appropriateness of a referral. They will also be able to provide the local MARAC administration pack with all the documentation and guidance for making referrals, including protocols and information-sharing agreements. Any agency receiving a disclosure of domestic violence is able to refer the case to the local MARAC once they have completed a Co-ordinated Action Against Domestic Abuse-Domestic Abuse, Stalking and Harrassment and Honour-based Violence (CAADA-DASH) risk identification checklist (RIC) and identified it as a high-risk case.

Relevant forms, agency tool kits and further information about the MARAC can be obtained through: [www.caada.org.uk](http://www.caada.org.uk)

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

Risk assessments using the CAADA-DASH RIC should be undertaken and cases identified as high risk should be referred to the local MARAC. Practitioners need to be aware of the contact details of their MARAC coordinator. Those unaware of their local MARAC coordinator should contact the local police CSU, or alternatively contact CAADA on 0117 317 8750 or at [www.caada.org.uk](http://www.caada.org.uk)

### 1.3 Key considerations when working with domestic violence

- The person coursing harm of the alleged domestic violence should not be informed of the domestic violence disclosures or of the referral to the MARAC
- Professionals should not attempt to mediate in cases of domestic violence, but should rather provide the individual who is experiencing the violence with information about specialist domestic violence services, where safe and appropriate to do so
- A CAADA-DASH domestic violence RIC should be undertaken with the adult at risk and must not be conducted in the presence of the person alleged to have caused the harm. This principle also applies when conducting any needs assessment or mental capacity assessment
- For those unable to speak directly to the adult at risk to complete the risk assessment, a referral can still be made to the MARAC based on the risks identified through the Safeguarding Adults process and based on professional judgement
- The mental capacity of the adult at risk needs to be established in regard to their wishes
- Positive intervention is an active approach to taking steps to reduce the risk. This may be done with or without the consent of the adult at risk, particularly where the risk of harm is regarded as high. Every effort should be made to engage the adult at risk in this process, where it is safe and appropriate to do so

- Consideration should be given to the context of the abuse. The interventions need to be proportionate to the risks identified having regard to the intent or motivation of the person causing the harm, for example, inadvertent harm caused by a carer
- When gathering information regarding the person alleged to have caused the harm, it is imperative that intelligence checks, history and background enquiries are made of appropriate agencies to ensure that when conducting the risk identification and assessment process, this is based on best information to enable effective intervention and defensible decisions. Identified risk factors and appropriate interventions to manage risk will be discussed at the strategy meeting
- Any activity connected to the person alleged to have caused the harm needs to be mindful of any potential risks that it may pose to the adult at risk. It is not a requirement in all cases to disclose information that is held if it will increase the risk
- Sensitive information about the alleged person who has caused the harm can be shared under Section 115 of the Crime and Disorder Act 1998, and the Data Protection Act 1998, provided that criteria outlined in the legislation are met
- The consent of the adult at risk must be obtained before sharing any information with relatives or friends. If the adult at risk has given consent but by sharing the information the risk to the person concerned is raised then the information should not be shared until that risk is removed
- Cases not reaching the threshold for MARAC or considered high risk will still be managed under the Safeguarding Adults process with strategy discussions taking place to develop appropriate plans to prevent escalation in circumstances and to provide appropriate support for the adult. Doing nothing is not an option.

## 1.4 Referrals to specialist domestic violence support services

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

Specialist domestic violence services provide support and advocacy to the person experiencing the domestic violence in relation to safety planning, housing options, legal options (that is, how to obtain an injunction) and counselling.

Those not aware of the specialist services available in their borough can contact their local Domestic Violence Coordinator (based within the local authority) or the National Domestic Violence Helpline on 0808 2000 247 to obtain this information.

### 1.4.1 Honour-based violence

Honour-based violence is a crime, and referral must always be made to the police. It has or may have been committed when families feel that dishonour has been brought to the family. Women are predominantly (but not exclusively) the victims, and the



violence is often committed with a degree of collusion from family members and/or the community. Many of these victims will contact police or other organisations. Many are so isolated and controlled that they are unable to contact the police.

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

#### 1.4.2 Forced marriage

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

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

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

#### 1.4.3 Multi-agency Public Protection Arrangements (MAPPA)

The purpose of the MAPPA framework is to reduce the risks posed by sexual and violent offenders in order to protect the public, including previous victims, from serious harm. The responsible authorities in respect of MAPPA are the police, prison and probation services who have a duty to ensure that MAPPA is established in each of their geographic areas to ensure the risk assessment and management of all identified MAPPA offenders (primarily violent offenders on licence or mental health orders and all registered sex offenders). The MPS, prison and probation services have a clear statutory duty to share information for MAPPA purposes.

Other organisations have a duty to cooperate with the responsible authority, including the sharing of information. These include:

- local authority children and family, and adult social care services
- PCTs and other health trusts and strategic health authorities (SHAs)
- Jobcentre Plus
- youth offender teams
- local housing authorities
- registered social landlords with accommodation for MAPPA offenders.

#### 1.4.4 Human trafficking

If an identified victim of human trafficking is also an adult at risk, the response will be coordinated under the Safeguarding Adults process. This will include organisations that have a role to play in dealing with victims of human trafficking, including the police, health trusts, immigrations officials and other relevant support services including those in the voluntary sector. The adult at risk should receive the support and advice they need and be safely repatriated if this is the future plan. If the victim is a child, the situation will be dealt with under the London child protection procedures.

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

There is a national framework to assist in the formal identification and help to coordinate the referral of victims to appropriate services; this is called the National Referral Mechanism. The UK Human Trafficking Centre takes referrals of adults and children identified as being the victims of trafficking. Local authorities can provide a range of assistance on a discretionary basis. The Centre now comes under the Serious and Organised Crime Agency (SOCA).

The police are the lead agency in managing responses to adults who are the victims of human trafficking.

#### 1.4.5 Exploitation by radicalisers who promote violence

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

There are a number of factors that may make the individual susceptible to exploitation by violent extremists. None of these factors should be considered in isolation but in conjunction with the particular circumstances of the individual: identity or personal crisis, particular personal circumstances, unemployment or underemployment and criminality. All of these may contribute to alienation from UK values and a decision to cause harm to symbols of the community or the state.

The Home Office leads on the anti-terrorism strategy, CONTEST, and PREVENT is part of the overall CONTEST strategy, aiming to stop people becoming terrorists or supporting violent extremism. Local safeguarding structures have a role to play for those eligible for adult protection.

#### 1.4.6 Abuse by another adult at risk

Where the person causing the harm is also an adult at risk, the safety of the person who may have been abused is paramount.

Organisations may also have responsibilities towards the person causing the harm, and certainly will have if they are both in a care setting or have contact because they attend the same place (for example, a day centre). The person causing the harm may themselves be eligible to receive an assessment. In this situation it is important that the needs of the adult at risk who is the alleged victim are addressed separately from the needs of the person causing the harm.

It will be necessary to reassess the adult allegedly causing the harm. This could involve a network meeting where the following could be addressed:

- the extent to which the person causing the harm is able to understand his/her actions
- the extent to which the abuse or neglect reflects the needs of the person causing the harm
- the likelihood that the person causing the harm will further abuse the victim or others.

The same principles and responsibilities to report a crime apply.

The appropriate community mental health team (CMHT) would be involved if the person alleged to have caused the abuse appears to have a mental illness or is showing signs of mental disturbance.

#### 1.4.7 Allegations against carers who are relatives or friends

There is a clear difference between unintentional harm caused inadvertently by a carer and a deliberate act of either harm or omission, in which case the same principles and responsibilities for reporting to the police apply.

In cases where unintentional harm has occurred this may be due to lack of knowledge or due to the fact that the carer's own physical or mental needs make them unable to care adequately for the adult at risk. The carer may also be an adult at risk. In this situation the aim of Safeguarding Adults work will be to support the carer to provide support and to help make changes in their behaviour in order to decrease the risk of further harm to the person they are caring for.

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

- whether the adult for whom they care has a learning disability, mental health problems or a chronic progressive disabling illness that creates caring needs which exceed the carer's ability to meet them
- the emotional and/or social isolation of the carer and the adult at risk
- minimal or no communication between the adult at risk and the carer either through choice, mental incapacity or poor relationship
- whether the carer is not in receipt of any practical and/or emotional support from other family members or professionals
- financial difficulties
- whether the carer has a lasting power of attorney or appointeeship

- a personal or family history of violent behaviour, alcoholism, substance misuse or mental illness
- the physical and mental health and well-being of the carer.

#### 1.4.8 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.

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

Where the person who is alleged to have caused the abuse or neglect has a relationship of trust with the adult at risk because they are a member of staff, a paid employee, a paid carer, a volunteer or a manager or proprietor of an establishment, the organisation will invoke its disciplinary procedures as well as taking action under the Safeguarding Adults policy and procedures. If a crime is suspected a report must always be made to the police, and referral must be made to the Independent Safeguarding Authority (ISA) if they have been found to have harmed or put at risk of harm an adult at risk.

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

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

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

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

#### 1.4.9 Abuse by children

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

#### 1.4.10 Child protection

The Children Act 1989 provides the legislative framework for agencies to take decisions on behalf of children and to take action to protect them from abuse and neglect.

Everyone must be aware that in situations where there is a concern that an adult at risk is or could be being abused or neglected and there are children in the same household, they too could be at risk. Reference should be made to the London child protection procedure, the local Safeguarding Children Board, inter-agency guidelines and internal protocols dealing with cross-boundary working if there are concerns about abuse or neglect of children and young people under the age of 18. Referral must be made to the relevant children and families department and the multi-agency safeguarding children policy and procedures.

#### 1.4.11 Transitions (care leavers)

Robust joint working arrangements between children's and adult services need to be put in place to ensure that the medical, psychosocial and vocational needs of children leaving care are addressed as they move to adulthood.

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

Good practice includes:

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

### 1.5 Safeguarding Adults structures

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

### 1.5.1 Everyone – all staff and volunteers

The first priority should always be to ensure the safety and protection of the adult at risk.

All staff and volunteers from any service or setting should know about the policy and procedures. All staff and volunteers from any service or setting who have contact with adults 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.

Staff or volunteers should:

- be aware that they must call the police and/or an ambulance where appropriate in situations where the abuse of the adult indicates an urgent need for medical treatment, or where there is immediate risk of harm indicating urgent action is needed to protect the person
- be authorised to make a report to the police, and if a crime has been committed, ensure action is taken to preserve evidence. This could be where there has been a physical or sexual assault, especially if the suspect is still at the scene
- share their concern with colleagues and seek advice and support
- know they must inform their line manager. If their line manager is implicated in the abuse then they should inform a more senior manager
- know what services are available and how to access help and advice for the adult at risk
- know how and where to make a direct referral, where speaking to a manager would cause delay
- know that they must make a clear factual record of their concern and the action taken.

### 1.5.2 Role and responsibility of managers in all organisations

The role and responsibility of the manager is:

- to ensure the alleged victim is made safe
- to ensure that any staff or volunteer who may have caused harm is not in contact with service users and others who may be at risk, for example, 'whistleblowers'
- to ensure that appropriate information is provided in a timely way.

The primary responsibility for coordinating information in response to a Safeguarding Adult concern is vested in the SAM, but the investigation may be undertaken by another organisation, for example, the MPS or a health trust. All managers in all organisations have a key role to play.

Managers 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 the Care Standards Act 2009 and ensure compliance with registration and outcomes and guidance on compliance, on quality and safeguarding and safety standards
- operate safe recruitment practices and routinely take up and check references
- adhere to and operate within their own organisation's 'whistleblowing' policy and support staff who raise concerns.

Managers of regulated activity providers must fulfil their legal obligations under the Vulnerable Groups Act 2006 and the Vetting and Barring Scheme as administered by the ISA. Managers have responsibility for making checks on and referring staff and volunteers who have been found to have harmed a vulnerable adult or put a vulnerable adult at risk from harm.

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

### **1.5.3 Local authorities**

#### **1.5.3.1 Safeguarding Adults Partnership Boards (SAPBs)**

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

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

#### **1.5.3.2 Lead coordinating agency**

Local authorities have the lead role in coordinating the multi-agency approach to safeguard adults at risk. This includes the coordination of the application of this policy and procedures, coordination 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 coordinating role, the local authority adult social care department, joint health and social care teams and CMHTs also have responsibility for coordinating the action taken by organisations in response to concerns that an adult at risk is being or is at risk of being abused or neglected.

The local authority should:

- ensure that any Safeguarding Adults concern is acted on in line with this policy and procedures
- coordinate the actions that relevant organisations take in accordance with their own duties and responsibilities. This does not mean that the local authorities undertake all activities under Safeguarding Adults – relevant organisations have their own roles and responsibilities
- ensure a continued focus on the adult at risk and due consideration to other adults or children
- ensure that key decisions are made to an agreed timescale
- ensure that an interim and a final protection plan are put in place with adequate arrangements for review and monitoring
- ensure that actions leading from investigation are proportionate to the level of risk and enable the adult at risk to be in control, unless there are clear recorded reasons why this should not be the case
- ensure independent scrutiny of circumstances leading to the concern and to Safeguarding Adults work
- facilitate learning the lessons from practice and communicate these to SAPBs.

#### **1.5.3.3 Lead councillor for Safeguarding Adults**

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

#### **1.5.3.4 Director of adult social services**

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

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

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

#### **1.5.3.5 Safeguarding Adults coordinator (or similar title)**

The Safeguarding Adults coordinator is responsible for ensuring the effective functioning of the SAPB and Safeguarding Adults systems across a borough. They may advise in complex cases.



### **1.5.3.6 Safeguarding Adults manager (SAM)**

The lead coordinating role in relation to individual cases is taken by senior staff of the local authority adult social care, the integrated/joint health and social care team, centralised Safeguarding Adults team or CMHTs who are designated SAMs. A SAM must be informed of any safeguarding concern arising in any organisation and has overall responsibility for coordinating the Safeguarding Adults process.

The SAM has overall responsibility to ensure that:

- the action being taken by organisations is coordinated and monitored
- the adult at risk is involved in all decisions that affect their daily life
- those who need to know are kept informed
- a decision is made in consultation with other relevant organisations to instigate the Safeguarding Adults process
- a multi-agency strategy meeting or discussion is held to determine how the Safeguarding Adults process will be conducted, who will conduct an investigation and to ensure decisions are recorded and copied to relevant organisations
- the response of the organisations involved in the Safeguarding Adults process is coordinated. The aim is to agree that where indicated a joint investigation will take place with agreement to share information in line with the information-sharing protocol
- a multi-agency case conference is convened and chaired and a record made of the decisions and circulated to all relevant organisations
- a protection plan is agreed with the adult at risk if they have mental capacity to participate in this, or in the best interests of the person if they have been assessed not to have mental capacity
- any safeguarding documentation is completed including monitoring information.

### **1.5.3.7 Emergency duty teams (EDTs) and out-of-hours services**

Local EDTs or out-of hours teams (social services and health) operate out of normal working hours, at weekends and over statutory holidays.

If a referral is made to the EDT which indicates an immediate or urgent risk, the officer will take any immediate steps necessary to protect the adult at risk including arranging emergency medical treatment, contacting the police and taking any other action to ensure that the adult at risk is safe.

EDT staff must also be aware that, if responding to an emergency, other adults may also be at risk.

A member of the EDT would not be responsible for a Safeguarding Adults investigation but it may be necessary to interview the alleged victim where:

- the allegation is serious, that is, life-threatening or likely to result in serious injury (in which case action would be coordinated with the police to ensure that any evidence is preserved)
- the referral is unclear

- there is a need to interview the adult at risk to ensure they can be safeguarded against further abuse if necessary.

Whether or not any immediate action is necessary the emergency duty officer (EDO) will record the facts concerning the alleged abuse or neglect and pass all relevant information to the appropriate duty team in adult social care or to a CMHT on the next working day. If the case is already allocated the EDO will notify the allocated worker.

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

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

#### **1.5.3.8 Complaints officers**

Local authorities have statutory complaints procedures. If a complaint received by a complaints officer could indicate that an adult is at risk, the complaints officer will bring this to the attention of the relevant Safeguarding Adults lead or other manager.

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

#### **1.5.4 Metropolitan Police Service (MPS)**

The investigation of crimes against adults at risk by the MPS is in accordance with the Safeguarding Adults at Risk Standard Operating Procedures. These give clear guidance to police officers and staff to ensure the safety and protection of adults at risk by providing a quality service to service users whether as employees, colleagues, victims, witnesses or strategic partners, and so on.

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

##### **1.5.4.1 Aims of the MPS Safeguarding Adults at Risk Policy**

- To hold people causing abuse accountable for their actions. Where criminal proceedings are deemed inappropriate, to work with partnership agencies and to identify courses of action.

- To work in effective partnership with other agencies to safeguard adults at risk.
- Where a criminal offence appears to have been committed, the police will be the lead investigating agency and will direct investigations in line with legal and other procedural protocols. A police investigation will be initiated at the outset and a comprehensive initial risk assessment undertaken.

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

The CSU Delivery Team, part of the Violent Crime Directorate, has the strategic and policy lead with overall responsibility for MPS delivery on domestic violence and hate crime performance and compliance, ensuring accountability and ownership. The team also leads on the Safeguarding Adults at Risk Policy.

#### **1.5.4.2 Barriers to reporting crimes**

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

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

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

There may also be practical barriers deterring the adult at risk, for example, someone with hearing difficulties may need a British Sign Language interpreter to be present. Given the culturally diverse nature of London's population, staff must be aware when dealing with Safeguarding Adults at Risk cases that there may be issues and barriers to reporting in addition to those outlined above. They may include fear of being identified as being vulnerable to family/friends, losing their home, carer or financial and emotional support. There may also be cultural matters that keep them isolated from services. An example of this is where a member of the extended family is the

carer of an adult at risk where the person may have to accept what has happened, as they do not recognise the particular behaviour as being abusive.

### 1.5.5 NHS-funded services

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

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

#### 1.5.5.1 Why is Safeguarding Adults relevant to the NHS?

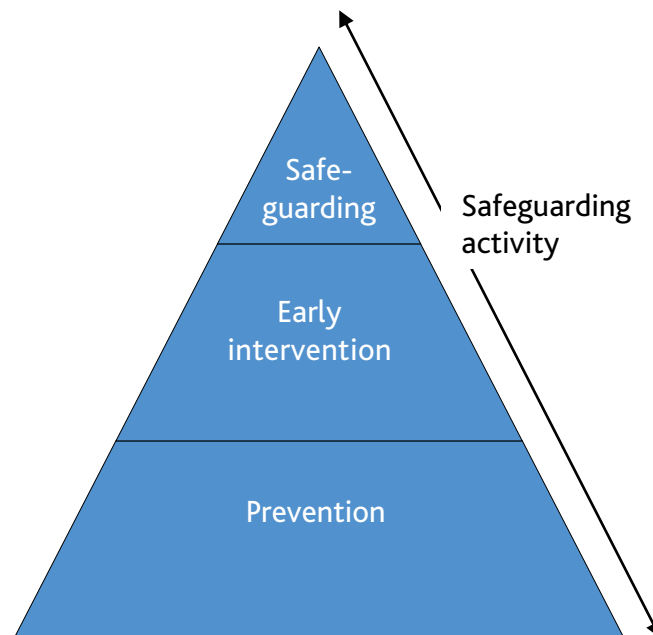
The NHS is accountable to patients for their safety and well-being through delivering high-quality care. This duty is underpinned by the NHS constitution that all providers of NHS services are legally obliged to take account of. Quality is defined as providing care that is effective and safe and which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

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

- preventing safeguarding concerns arising, through provision of high-quality care
- providing effective responses where harm or abuse occurs, supporting the patient's choices through multi-agency Safeguarding Adults procedures

**Figure 1: Safeguarding as a continuum**



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

- is genuinely centred on patients and carers
- achieves quality and outcomes that are among the best in the world
- refuses to tolerate unsafe and substandard care
- eliminates discrimination and reduces inequalities in care
- is transparent, with clearer accountabilities for quality and results
- gives citizens a greater say in how the NHS is run
- is less insular and fragmented, and works much better across boundaries with local authorities and between hospitals and practices.

However, learning from the *No secrets* review (DH, 2000) and investigations into NHS failures identifies that we have some way to go to achieve this vision of safeguarding adults.

Recurrent themes are that:

- neglect and abuse arise in the absence of effective prevention and early warning systems
- neglect and abuse are not always recognised
- where neglect or abuse is recognised within services, there is lack of transparency and openness in investigation – incidents are not managed through multi-agency Safeguarding Adults procedures
- Safeguarding Adults is often seen as the responsibility of others such as the local authority
- the patient's voice is not heard
- patients are not empowered to make choices about their care and protection.

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

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

- **Quality:** clinical risk and poor patient experience arise from poor care, neglect or abuse.
- **Innovation:** Safeguarding Adults involves working collaboratively and creatively with patients, public and partner agencies to address health, well-being and safety.
- **Prevention:** preventing harm must be the primary aim for the patients' well-being and efficiency of services.
- **Productivity:** failures of care are costly for the service as well as the patient. The ultimate risk to productivity is through deregistration in the event of non-compliance with CQC's 'Essential Standards of Quality and Safety'.

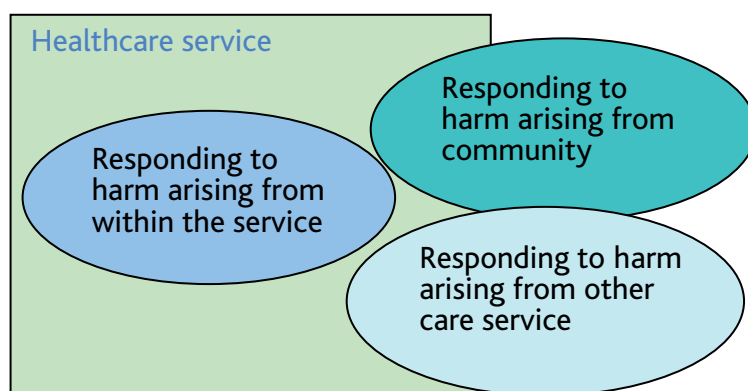
Health services may be involved in Safeguarding Adults concerns arising in:

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

#### 1.5.5.2 Who may require support in Safeguarding Adults?

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

**Figure 2: Healthcare services response to Safeguarding Adults**



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

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

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

#### **1.5.5.3 GPs' role in Safeguarding Adults**

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

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

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

#### **1.5.5.4 Patient-led safeguarding**

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

The following defines a positive patient experience:

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

#### **Key messages from the *No secrets* consultation, July 2009**

- People felt taken over by the Safeguarding Adults process
- People wanted to be listened to
- People did not want professionals to make decisions for them
- People did not want to be treated as children
- Safeguarding is a person's own responsibility but can be supported by others
- People wanted to make choices and direct the help/support they receive
- Safety should not be at the cost of other qualities of life

#### 1.5.5.5 Role of all health staff

Health services will:

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

#### 1.5.5.6 Ownership and strategic leadership

##### **Safeguarding leadership: the role of Strategic Health Authorities (SHAs)**

NHS London has an executive lead who is responsible for the overall monitoring of progress of Safeguarding Adults best practice. The role of Strategic Health Authorities (SHAs) is to support the development of adult safeguarding within the local region. They will develop a London-wide approach to the development of safeguarding across the NHS, focusing on promoting and embedding joint working processes, and will influence PCT strategic plans to include safeguarding adults.

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

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

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

In addition, NHS London will share responsibility for improving Safeguarding Adults performance across health and social care by developing their partnership role with



local directors of adult social care with their deputy regional directors of public health.

NHS London is leading on a strategic PREVENT programme and is rolling out a regional and local framework across NHS organisations in London. PREVENT is part of the overall Home Office anti-terrorism strategy, CONTEST, which aims to support individuals who are vulnerable to recruitment by violent extremists. Healthcare providers have an important role to play in minimising exploitation of vulnerable individuals and the ability to deliver on the PREVENT strategy at a local level.

### **Safeguarding role of the NHS trust boards**

NHS trust boards should ensure that the health contribution to safeguarding and promoting the welfare of adults at risk is implemented effectively across the whole local health economy, both through the PCT's commissioning arrangements and through the responsibilities of the provider boards and committees. Where practice-based commissioners undertake commissioning of services, this should be done in partnership with the PCT who will ensure their safeguarding duties are fulfilled.

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

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

The trust board member will also prepare an annual report for the local multi-agency SAPB.

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

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

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

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

### **Membership of multi-agency SAPBs**

Members of SAPBs from health services should be of sufficient seniority that they can represent their organisation with authority and make decisions on its behalf. They will submit an annual report to the SAPB, setting out a summary of Safeguarding Adults incidents, responses and initiatives within their agency. The report will contribute to an annual audit of Safeguarding Adults activity by the local SAPB on which to base the annual development and training plans.

#### **1.5.5.7 London Ambulance Service (LAS)**

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

LAS 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. LAS staff should also follow local procedures for contacting the local authority.

#### **1.5.5.8 Patient Advice and Liaison Services (PALS) and complaints departments**

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

PALS 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 make a referral to the relevant local authority to ensure that appropriate action is taken under the multi-agency policy and procedures.

#### **1.5.6 London Fire Brigade**

London Fire Brigade personnel visit people in their homes when carrying out a Home Fire Safety Visit. Personnel carry out the visit in accordance with London Fire Brigade guidance and policy, providing fire safety advice and installing, where appropriate,

one or more smoke alarms. Where personnel have a concern about an adult at risk they follow procedure and inform their line manager who then takes action, which may involve referral to another agency.

Where other agencies visit people in their homes, the London Fire Brigade advises those staff to look for any indication of fire risk. This may include: burn marks made by carelessly discarded smoking materials; evidence of hoarding, where access or egress may be impeded or could be fuel for a potential fire; and a build-up of grease on cooking equipment (chip pans in particular). The use of oxygen is also noteworthy, particularly where the user is also a smoker. Staff 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 advise the local fire station so that they may contact the occupier to arrange for a Home Fire Safety Visit.

### 1.5.7 All organisations providing services to adults at risk

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

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

## 1.6 Other organisations' Safeguarding Adults responsibilities

### 1.6.1 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. It has 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.

Where the CQC receives information about a possible Safeguarding Adults situation or issue, then that information must be immediately brought to the attention of the lead regulatory inspector for the service, or the duty inspector. If, on a review of the information, there appears to be a Safeguarding Adults concern, the CQC should pass the information to the local authority through the locally determined referral point. If there is an indication of potential criminal activity, a referral must also be made to the MPS.

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

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

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

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

The CQC would expect that registered providers and managers who are not implicated in the alleged abuse, people who use the service and/or their representatives are invited to attend meetings or to participate in the discussions. The CQC will assist the SAM in determining whether registered people are or should be included as full partners in the strategy discussion.

Whether relevant CQC staff attend or not they must be sent copies of minutes of the agreed strategy. The regulatory inspector is responsible for ensuring that communication is established. If they have any concern about the proposed protection plan, they will discuss this with the regulatory manager in the first instance.

Where the allegation suggests breaches of regulation and standards, the CQC may conduct enquires or initiate a random inspection, in which case they will inform the relevant SAM. This activity may take place as well as other investigations being undertaken by another organisation. If the police are investigating, the CQC will coordinate their action with them.

The outcome of any assessment or investigation must also be shared with the CQC if it is related to a regulated service. The CQC have a role in ensuring adherence to any part of a Safeguarding Adults plan that relates to service compliance with regulation and standards.

Where the CQC have not undertaken any activity in relation to the initial concern, they should be notified of the outcome of the Safeguarding Adults process. If the allegation is substantiated and indicates a breach of regulation or standards, the CQC will consider whether any further regulatory activity is required and will inform the relevant SAM of their decision.

### 1.6.2 Court of Protection

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

- decide whether a person has capacity to make a particular decision for themselves

- make declarations, decisions or orders on financial and welfare matters affecting people who lack capacity to make such decisions
- appoint deputies to make decisions for people lacking capacity to make those decisions
- decide whether a lasting power of attorney or an enduring power of attorney is valid
- remove deputies or attorneys who fail to carry out their duties.

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

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

- particularly difficult decisions to be made
- disagreements that cannot be resolved by any other means
- ongoing decisions needed about the personal welfare of a person who lacks capacity to make such decisions for themselves
- matters relating to property and/or financial issues to be resolved
- serious healthcare and treatment decisions, for example, withdrawal of artificial nutrition or hydration
- concerns that a person should be moved from a place where they are believed to be at risk
- concerns or a desire to place restrictions on contact with named individuals because of risk or where proposed Safeguarding Adults actions may amount to a deprivation of liberty outside of a care home or hospital.

#### **1.6.2.1 Court-appointed deputies**

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

#### **1.6.3 Office of the Public Guardian (OPG)**

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

- setting up and managing separate registers of lasting powers of attorney, of enduring powers of attorney and of court-appointed deputies
- supervising deputies
- sending Court of Protection visitors to visit people who lack capacity and also those for whom it has formal powers to act on their behalf
- receiving reports from attorneys acting under lasting powers of attorney and deputies
- providing reports to the Court of Protection

- dealing with complaints about the way in which attorneys or deputies carry out their duties.

The OPG Safeguarding Vulnerable Adults Policy states that the organisation will strive to ensure that vulnerable adults 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's Safeguarding Vulnerable Adults Policy covers any person:

- who has a deputy appointed by the Court of Protection or
- is the donor of a registered enduring power of attorney or lasting power of attorney or
- is someone for whom the court authorised a person to carry out a transaction on their behalf under Section 16(2) of the Mental Capacity Act (single orders). This includes young people aged 16 or over who are defined as adults under the Mental Capacity Act.

The OPG may be involved in Safeguarding Vulnerable Adults in a number of ways, including:

- promoting and raising awareness of legal safeguards and remedies, for example, lasting powers of attorney and the services of the OPG and the Court of Protection
- receiving reports of abuse relating to vulnerable adults ('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 care social services and the police.

#### **1.6.3.1 Investigations undertaken by the OPG**

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.

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

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

The OPG will refer all concerns and allegations relating to people not covered by the OPG Safeguarding Vulnerable Adults 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.

#### 1.6.4 Housing organisations

Staff of housing organisations are in a position to identify tenants who are vulnerable and are at risk of abuse, neglect and exploitation. *Supporting People* housing has become a major provider of housing and support services for adults with a wide range of needs. The quality of their services is regulated through the Quality Assessment Framework, which includes standards that they must meet with regard to safeguarding adults from 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 protection plans.

#### 1.6.5 Crown Prosecution Service (CPS)

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

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

The CPS has a key role to play in making sure that special measures are put in place to support vulnerable or intimidated witnesses to give their best evidence. Special measures were introduced by the Youth Justice and Criminal Evidence Act 1999 and are available both in the Crown Court and in the magistrates' courts. These include the use of trained intermediaries to help with communication, screens and arrangements for evidence and cross-examination to be given by video link.

#### 1.6.6 The Coroner

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

- where there is an obvious and serious failing by one or more organisations

- where there are no obvious failings, but the actions taken by organisations require further exploration/explanation
- where a death has occurred and there are concerns for others in the same household or other setting (such as a care home) or
- deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions are identified by the Coroner or his or her officers
- In the above situations the local SAPB should give serious consideration to instigating a serious case review.

### 1.6.7 The 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 share information and work in partnership with other agencies including local authorities and health services, and contribute to local MAPPA 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.

## 1.7 Commissioning

### 1.7.1 Commissioning governance

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

- ensure that agencies from whom services are commissioned know about and adhere to relevant registration requirements and guidance
- ensure that all documents such as service specifications, invitations to tender, service contracts and service-level agreements adhere to the multi-agency Safeguarding Adults policy and procedures
- ensure that managers are clear about their leadership role in Safeguarding Adults in ensuring the quality of the service, the supervision and support of staff, and responding to and investigating a concern about an adult at risk
- commission a workforce with the right skills to understand and implement Safeguarding Adults principles
- ensure staff have received induction and training appropriate to their levels of responsibility



- liaise with the local SAPB and regulatory bodies and make regular assessments of the ability of service providers to effectively safeguard service users
- ensure that services routinely provide service users with information in an accessible form about how to make a complaint and how complaints will be dealt with
- ensure that service providers give information to service users about abuse, how to recognise it and how and to whom they can raise a concern
- ensure Safeguarding Adults are always included in the monitoring arrangements for contracts and service-level agreements
- ensure that commissioners (and regulators) regularly audit reports of risk of harm and require providers to address any issues identified.

### 1.7.2 Personal budgets and self-directed care

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

Commissioners have a responsibility to:

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

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

### 1.7.3 Commissioned services

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

In addition, provider organisations' internal guidelines should cover:

- a 'whistleblowing' policy which sets out assurances and protection for staff to raise concerns

- how to work within best practice as specified in contracts
- how to meet the standards in the Health and Social Care Act 2008 (regulated activities) and the Care Quality Act 2009
- how to fulfil their legal obligations under the Vulnerable Groups Act 2006 and the Vetting and Barring Scheme as administered by the ISA
- robust recruitment arrangements
- training and supervision for staff.

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

## 1.8 Support for those involved in the Safeguarding Adults process

### 1.8.1 Supporting the adult at risk

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

### 1.8.2 Advocates

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

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

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

### 1.8.3 Independent mental capacity advocates (IMCAs)

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

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

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

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

- restrictions on contact with certain people
- temporary or permanent moves of accommodation
- the police interviewing the person or collecting forensic evidence which may support a prosecution
- increased support or supervision
- an application to the Court of Protection
- restrictions on accessing specific services and/or places
- access to counselling or psychology with the aim of reducing the risk of further abuse.

#### **1.8.4 Support for vulnerable witnesses**

##### **1.8.4.1 Witness support and special measures**

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

Special measures are those specified in the Youth Justice and Criminal Evidence Act 1999 and will be used to assist eligible witnesses. The measures can include the use of screens in court proceedings, the removal of wigs and gowns, the sharing of visually recorded evidence-in-chief, cross-examination and re-examination and the use of intermediaries and aids to communication.

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

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

#### **1.8.4.2 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.

#### **1.8.4.3 Keeping families and others concerned informed and supported**

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

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

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

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

#### **1.8.5 Responsibilities to those who are alleged to have caused the harm**

Adults who are alleged to have abused an adult at risk have the right to be assumed innocent until the allegations against them are proved on the evidence. Whether they are a member 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 an adult at risk, they should be provided with appropriate support. If the person causing harm is a young person or has a mental disorder, including a learning disability, and they are interviewed at the police station, they are entitled to the support of an appropriate adult under the provisions of the Police and Criminal Evidence Act 1984 Code of Practice. (Refer to local Police and Criminal Evidence Act procedures and agreements.)

### **1.9 Arrangements for managing Safeguarding Adults**

#### **1.9.1 Information sharing**

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 CPS, and organisations which provide advocacy and support where these organisations are involved in Safeguarding Adults enquiries, including raising an alert and participating in an investigation and/or making a contribution to protection plans.

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

- Adults have a right to independence, choice and self-determination. This right extends to them being able to have control over information about themselves and to determine what information is shared. Even in situations where there is no legal requirement to obtain written consent before sharing information, it is good practice to do so
- The person's wishes should always be considered, however, protecting adults at risk establishes a general principle that an incident of suspected or actual abuse can be reported more widely and that in so doing, some information may need to be shared among those involved
- Information given to an individual member of staff belongs to the organisation and not to the individual employee. An individual employee cannot give a personal assurance of confidentiality to an adult at risk
- An organisation should obtain the adult at risk's written consent to share information and should routinely explain what information may be shared with other people or organisations
- Difficulties in working within the principles of maintaining the confidentiality of an adult should not lead to a failure to take action to protect the adult from abuse or harm
- Confidentiality must not be confused with secrecy, that is, the need to protect the management interests of an organisation should not override the need to protect the adult
- Staff reporting concerns at work ('whistleblowing') are entitled to protection under the Public Interest Disclosure Act 1998

Decisions about what information is shared and with whom will be taken on a case-by-case basis. Whether information is shared with or without the adult at risk's consent, the information shared should be:

- necessary for the purpose for which it is being shared
- shared only with those who have a need for it
- be accurate and up to date
- be shared in a timely fashion
- be shared accurately
- be shared securely.

The information-sharing protocol sets out the following guidance for sharing information:

- sharing information with consent

- sharing information without consent
- information sharing when the person does not have capacity to consent
- sharing information between adults and children's services
- sharing information with the MPS.

### 1.9.2 Risk assessment and management

Risk assessment that includes the assessment of risks of abuse, neglect and exploitation of people using services should be integral in all assessment and planning processes including assessments for self-directed support and the setting up of personal budget arrangements. Assessment of risk is dynamic and ongoing during the Safeguarding Adults process. It should be reviewed throughout the process so that adjustments can be made in response to changes in levels and nature of risk. The primary aim of a Safeguarding Adults risk assessment is to assess:

- current risks that people face
- potential risks they and other adults may face.

A Safeguarding Adults risk assessment will determine:

- what the actual risks are – the harm that has been or may be caused and the level of severity of that harm and the views and wishes of the adult at risk
- the person's ability to protect themselves
- who or what is causing the harm
- factors that contribute to the risk, for example, personal, environmental or relationships that result in increased or decreased risk
- the risk of future harm from the same source.

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

- what action must be taken immediately to protect the person at risk
- what needs to be in place to meet the need for an interim care plan
- when and how quickly a strategy meeting or discussion needs to take place
- a proportionate response to the particular situation to manage the risk posed to the person who has been harmed and others who may be at risk from the person alleged to have caused the harm
- what measures need to be taken to address risks that are caused by the setting which is providing care to the person at risk
- what needs to be put in place to meet the ongoing support needs of the person at risk.

#### 1.9.2.1 Involving the adult at risk

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 people at risk.

### **Vital interest**

If the adult at risk has the mental capacity to make informed decisions about their safety and they do not want any action to be taken, this does not preclude the sharing of information under Safeguarding Adults procedures with relevant professional colleagues. This is to enable professionals to assess the risk of harm and to be confident that the adult at risk is not being unduly influenced or intimidated, and is aware of all the options. This will also enable professionals to check the safety and validity of decisions made. It is good practice to inform the adult at risk that this action is being taken unless doing so would increase the risk of harm.

### **Best interest**

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

### **Public interest**

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

### **Personal decisions**

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

A person with mental capacity may choose to live in a situation which is seen as unsafe by professionals, if the alternatives they are being offered are unacceptable to them. They do not, however, have a right to make decisions about the protection other people may need where they may also be at risk from the same person, service or setting.

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

### 1.9.2.2 Complaints and appeals regarding the Safeguarding Adults process

#### Complaints

Complaints received from any source about the Safeguarding Adults practice and arising from the Safeguarding Adults process should be handled by the relevant complaints procedures of the organisation about which the complaint has been made. If more than one organisation has been named or is implicated in the complaint, the complaints officers from the named organisations must reach joint agreement with the complainant about how the complaint investigation will be taken forward.

If the complaint results from the experience of the adult protection/safeguarding process by the adult at risk, their carer, family member or personal representative and/or from a breakdown of inter-agency working, the relevant SAM and the chair of the multi-agency SAPB must be notified of the complaint and the findings.

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

This procedure does not apply to:

- complaints or representations relating to services that are delivered by individual organisations as a result of strategy/case conference decisions – although these may form part of a protection plan review
- complaints about an individual professional.

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

If differences or disputes arise from a complaint which involves different local authorities or health authorities, for example, between a host and commissioning authority, reference should be to senior managers within the respective organisations up to directorate level if disagreements cannot be resolved.

#### Appeals

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

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

When considering what action to take as a result of an appeal the following should be considered:



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

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

The Ombudsman recommended that there should be an appeals process included within Safeguarding Adults procedures and they set out the conditions to consider an appeal as follows:

- When there has been an obvious deviation in the Safeguarding Vulnerable Adults planning and investigation process
- When there has been a flaw in the decision making made at a case conference or strategy meeting, that is, when a decision made without key information has been presented or where information has not been taken properly into account
- When one agency has evidence that other agencies were involved in the issues but have not been brought into the decision-making process, for example, the role of PCT and social services staff in the support of a private/voluntary provider
- When new information is submitted to the Safeguarding Vulnerable Adults investigation process following the outcome of the case conference
- When a conflict of interest has been identified in the make-up of the investigation team and or the chair of the Safeguarding Vulnerable Adults meeting

## 2 Procedures

### 2.1 Introduction

The seven key stages of the Safeguarding Adults process are as follows:

- Stage One: Raising an alert
- Stage Two: Making a referral
- Stage Three: Strategy discussion or meeting
- Stage Four: Investigation
- Stage Five: Case conference and protection plan
- Stage Six: Review of the protection plan
- Stage Seven: Closing the Safeguarding Adults process

During these stages, key considerations are:

- supporting and enabling the adult at risk to achieve outcomes that they see as the best for them, where possible
- the need for the person at risk to be represented by an advocate, including an IMCA
- assessing and addressing risk
- taking action to protect and support the adult
- deciding whether a mental capacity assessment is needed to clarify issues of consent
- taking appropriate action for the person causing harm
- taking appropriate action with a service and/or its management if they have been culpable, ineffective or negligent
- identifying any lessons to be learnt for the future, including recommendations for any changes to the organisation and service delivery.

Table 2.1 summarises what is involved in the seven key stages. If, at any stage, a SAM feels that the issue is no longer appropriate for the Safeguarding Adults process, it can be closed down. The seventh stage – closing the Safeguarding Adults process – is only for those cases that go through all of the stages, including review.

The SAM has a responsibility to respond to the person who made the referral, and to reassure them that appropriate action has been taken. The SAM will make the decision as to when this response should be made.

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

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

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

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

## 2.2 Risk assessment and management

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

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

Risk assessment will seek to determine:

- what the actual risks are – the harm that has been caused, the level of severity of the harm, and the views and wishes of the adult at risk
- the person's ability to protect themselves
- who or what is causing the harm
- factors that contribute to the risk, for example, personal, environmental, relationships, resulting in an increase or decrease to the risk
- the risk of future harm from the same source.

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

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

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

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

The risk assessment should:

- establish the facts of the abuse or neglect and inform the protection plan
- assess what service provision may be needed by the adult at risk and/or, where indicated, their carer
- gain information to help inform decisions about what legal powers may be relevant to a protection plan
- ensure that forensic and other evidence is collected and preserved, and relevant files and documents are secured, using the appropriate powers of partner organisations where necessary
- ensure that any other assessments required are carried out
- establish if there is a need to protect other adults at risk and find out what is needed to protect them
- identify the person causing the harm if their identity is not known and establish where they are
- find out if the person causing the harm is also a service user
- decide if domestic violence is indicated and the need for referral to a MARAC
- identify people causing harm who should be referred to MAPPA
- identify whether a child (under 18 years) is at risk.

**Table 2.1: Seven key stages of the Safeguarding Adults process**

Stage	Activity	Responsibility	Timescale
<b>Stage One</b> Raising an alert	<ul style="list-style-type: none"> <li>• Act to protect adult at risk</li> <li>• Deal with immediate needs</li> <li>• Report to line manager</li> <li>• Consider reporting to the police, if a crime</li> <li>• Record</li> </ul>	Everyone with a duty of care	Immediately, if emergency <i>or</i> within same working day (this should be within four hours)
<i>Decision</i>	<ul style="list-style-type: none"> <li>• Take any immediate management action to identify and address the risk</li> <li>• Decide if a referral is needed</li> <li>• If NHS, consider reporting as serious incident (SI)</li> </ul>	Alerting manager Safeguarding Adults lead Member of staff if appropriate	Immediately <i>or</i> within 24 hours
<b>Stage Two</b> Making a referral	<ul style="list-style-type: none"> <li>• Refer to Safeguarding Adults referral point</li> <li>• Report to the police, if a crime</li> <li>• If NHS, make a report under SI procedures</li> <li>• Notify CQC if necessary</li> <li>• Gather initial information</li> <li>• Clarify facts</li> </ul>	Adult at risk (carer, friend, relative) Manager Safeguarding Adults lead Other professional Any staff in emergency	

Stage	Activity	Responsibility	Timescale
<i>Decision</i>	<ul style="list-style-type: none"> <li>Evaluate risk</li> <li>Decide if Safeguarding Adults procedures apply</li> <li>Agree interim protection plan</li> <li>(Police investigation may have begun)</li> <li>Decide if a strategy meeting or discussion is needed</li> </ul>	SAM and relevant partner organisations	Within 24 hours of referral
<b>Stage Three</b> Strategy discussion or meeting	<ul style="list-style-type: none"> <li>Evaluate risk</li> </ul>	SAM and relevant partner organisations Adult at risk as appropriate	The same day or within five working days from receipt of the Safeguarding Adults referral
<i>Decision</i>	<ul style="list-style-type: none"> <li>Decide if investigation needed</li> <li>Agree investigation plan</li> <li>If not Safeguarding Adults agree appropriate action</li> <li>If not Safeguarding Adults close process at this point</li> </ul>	SAM and relevant partner organisations Adult at risk as appropriate	
<b>Stage Four</b> Investigation	<ul style="list-style-type: none"> <li>Conduct investigation</li> <li>Re-evaluate risk</li> <li>Collate evidence and share with involved organisations</li> <li>Produce and distribute report</li> </ul>	Coordinated by SAM with relevant partner organisations	Within 20 days from receipt of referral
<b>Stage Five</b> Case conference and protection plan	<ul style="list-style-type: none"> <li>Receive investigation evidence</li> <li>Evaluate risk</li> <li>Formulate protection plan</li> <li>Close Safeguarding Adults process</li> <li>Keep under review</li> </ul>	Coordinated by SAM with relevant partner organisations Adult at risk/family/advocate	Within five working days from receipt/distribution of the safeguarding investigation report (or as agreed at strategy discussion or meeting)
<i>Decision</i>	<ul style="list-style-type: none"> <li>Agree outcome</li> <li>Agree review</li> </ul>		
<b>Stage Six</b> Review of the protection plan	<ul style="list-style-type: none"> <li>Review the protection plan</li> <li>Evaluate risk</li> </ul>	Coordinated by SAM with relevant partner organisations Adult at risk/family/advocate	Within three months of case conference or as agreed at case conference

Stage	Activity	Responsibility	Timescale
<b>Stage Seven</b> Closing the Safeguarding Adults process	<ul style="list-style-type: none"> <li>• Complete Safeguarding Adults process</li> <li>• Sign off Safeguarding Adults process</li> <li>• Review process continues</li> <li>• Decide if a referral to a serious case review is required</li> <li>• Dissemination of lessons learnt</li> <li>• Process may also be closed pending outcome of prosecution</li> </ul>	Signed off by SAM	On agreement with other organisations and adult at risk

### 2.3 Stage One: Raising an alert

This section covers:

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

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

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

A concern may be:

- a direct disclosure by the adult at risk
- a concern raised by staff or volunteers, others using the service, a carer or a member of the public
- an observation of the behaviour of the adult at risk, of the behaviour of another person(s) towards the adult at risk or of one service user towards another.

Alerts may be made to Safeguarding Adults referral points by people who are not managers, staff or volunteers of an organisation, including family members, friends, neighbours and the adult at risk themselves. These people should see Stage Two: Making a referral, for more information.

## **2.3.1 Responsibilities of the person raising the alert**

### **2.3.1.1 Taking immediate action**

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

### **Evidence gathering and victim care**

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

### **Preserving evidence**

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

- Try not to disturb the scene, clothing or victim if at all possible
- Secure the scene, for example, lock the door
- Preserve all containers, documents, locations, etc
- Evidence may be present even if you cannot actually see anything
- If in doubt contact the police and ask for advice.

### **2.3.1.2 Responding to an adult at risk who is making a disclosure**

- Assure them that you are taking them seriously
- Listen carefully to what they are telling you, stay calm, get as clear a picture as you can, but avoid asking too many questions at this stage
- Do not give promises of complete confidentiality
- Explain that you have a duty to tell your manager or other designated person, and that their concerns may be shared with others who could have a part to play in protecting them

- Reassure them that they will be involved in decisions about what will happen
- Explain that you will try to take steps to protect them from further abuse or neglect
- If they have specific communication needs, provide support and information in a way that is most appropriate to them
- Do not be judgemental or jump to conclusions.

#### **2.3.1.3 Considering the person alleged to have caused harm**

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

#### **Making a record**

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

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

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

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

#### **2.3.1.4 Informing a manager**

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



### 2.3.1.5 Referring

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

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

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

### 2.3.2 Responsibilities of the alerting manager

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

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

#### 2.3.2.1 Supporting immediate needs

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

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

#### 2.3.2.2 Speaking to the adult at risk

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

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

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

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

#### **2.3.2.3 Person alleged to have caused harm**

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

#### **2.3.2.4 Deciding whether or not to make a referral**

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

A referral should be made when:

- the person is an adult at risk and there is a concern that they are being or at risk of being abused or neglected, and at risk of significant harm

- the adult at risk has capacity to make decisions about their own safety and wants this to happen
- the adult at risk has been assessed as not having capacity to make a decision about their own safety, but a decision has been made in their best interests to make a referral
- a crime has been or may have been committed against an adult at risk without mental capacity to report a crime and a 'best interests' decision is made
- the abuse or neglect has been caused by a member of staff or a volunteer
- other people or children are at risk from the person causing the harm
- the concern is about institutional or systemic abuse
- the person causing the harm is also an adult at risk.

### 2.3.3 Factors to consider when raising an alert

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

### Getting the consent of the adult at risk at referral stage

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

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

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

### 2.3.3.1 Making a decision not to refer

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

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

### 2.3.3.2 Making a decision to refer without consent

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

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

The adult at risk would normally be informed of the decision to refer and the reasons, unless telling them would jeopardise their safety or the safety of others.

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

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

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

### 2.3.3.3 Who should be informed?

Where relevant the alerting manager should consider informing:

- the unit or service manager responsible for the management of the service
- the Safeguarding Adults lead in the organisation or service
- the police, if a crime has been or may be committed

- the area CQC if the adult is living in a care home, receiving personal care or another registered resource or service
- the relevant children and families team if children are also at risk from harm.

#### **2.3.3.4 Recording**

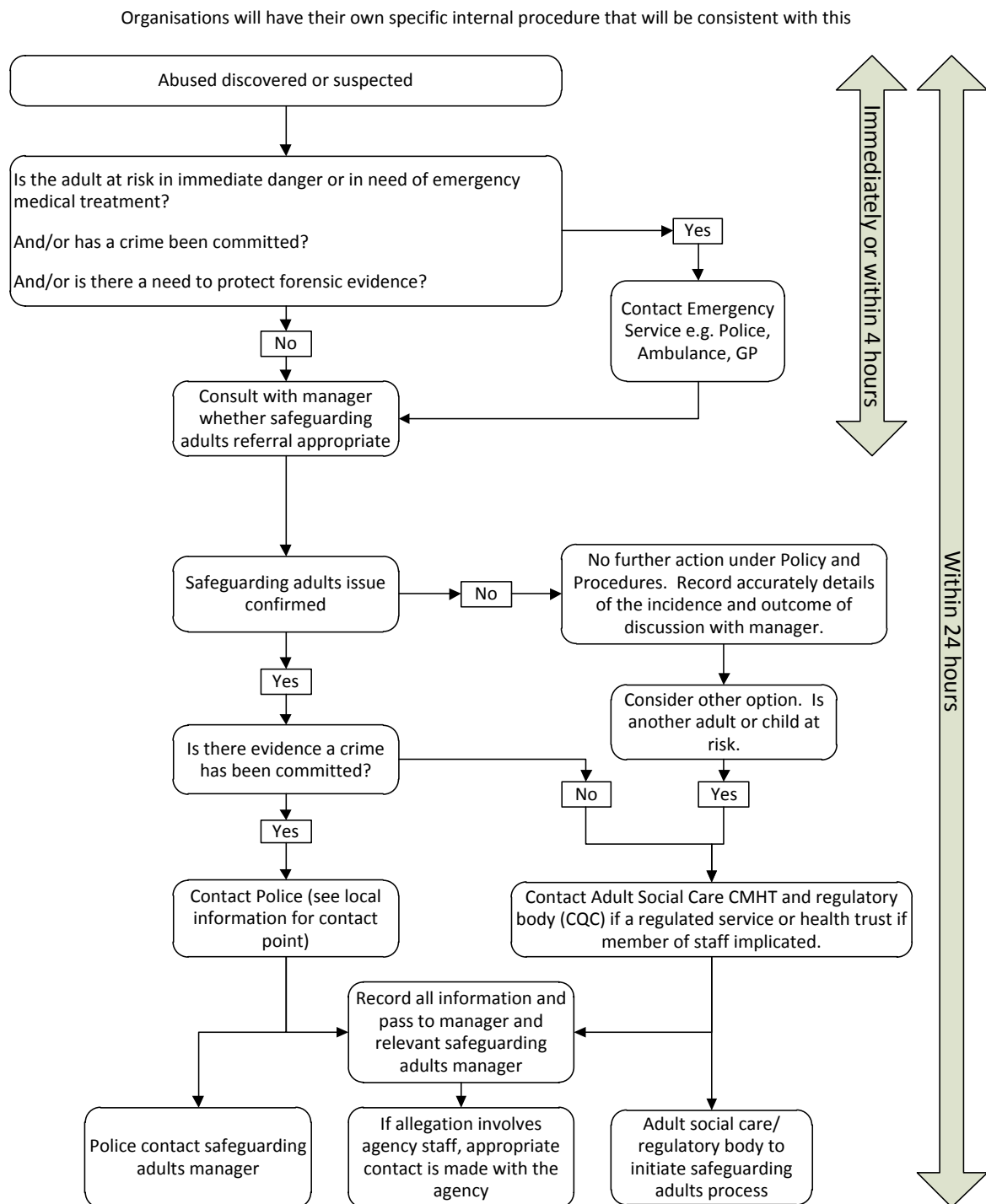
If not already done so by the alerter, the person making the referral must record:

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

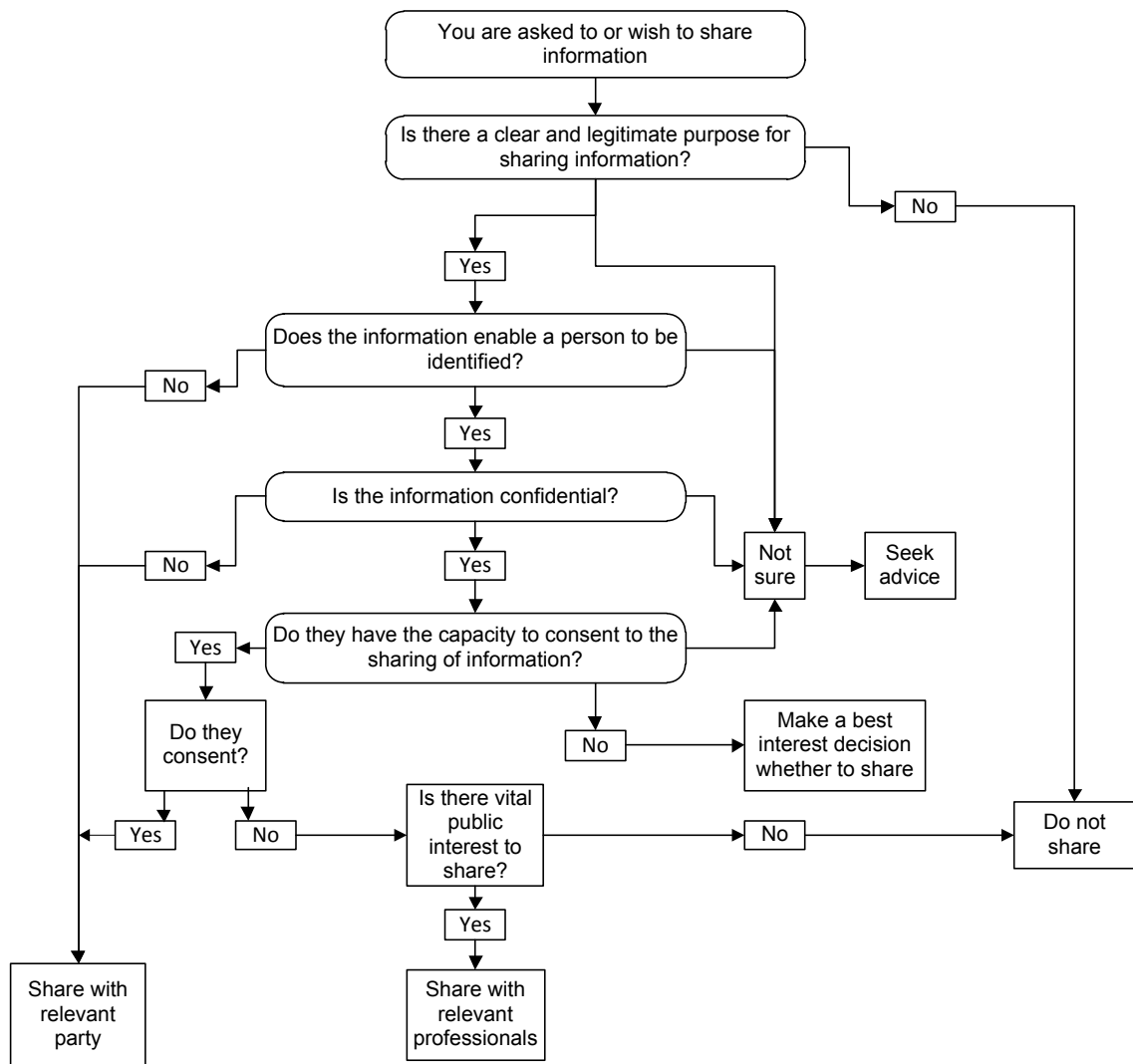
#### **2.3.3.5 Supporting staff**

Managers are responsible for:

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

**Figure 2.1: Alerting action to be taken after becoming aware**

**Figure 2.2: Flowchart of key questions for information sharing**



#### Key principles of information sharing

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

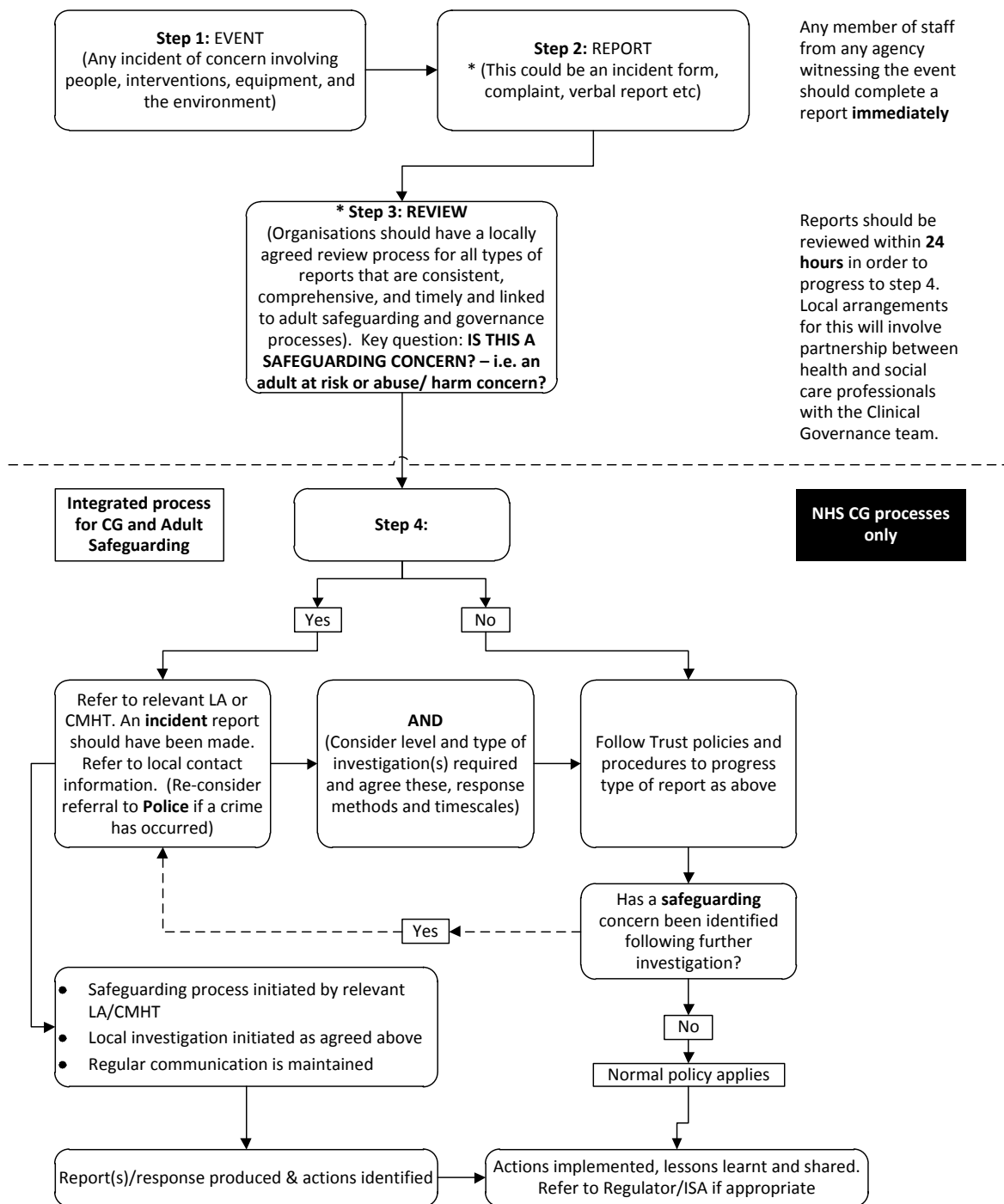
Record the information sharing decision and your reasons, in line with your agency's or local procedures.

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

Figure 2.3: Clinical governance and Adult Safeguarding



Ref: Adapted from Clinical Governance and Adult Safeguarding. An Integrated Process. DH February 2010.



## 2.4 Stage Two: Making a referral

This section covers:

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

A referral is the direct reporting of an allegation, concern or disclosure to a Safeguarding Adults referral point – usually a local authority social work team or CMHT. A referral will place the information about the concern in a multi-agency context.

A referral begins a process of gathering facts, assessment of the allegation, assessment of the adult at risk's needs and a risk assessment to decide whether the Safeguarding Adults policy applies. This should be done in consultation with the alerting manager and all relevant organisations. This decision must be made on the same working day or within 24 hours of the referral reaching the appropriate team.

### 2.4.1 Where to refer to and how to make a referral

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

The referrer may also be asked to complete a multi-agency referral form and send it to the relevant referral point as instructed on the form. If the referral is made by a member of the public, a member of the family, a friend, a carer, a neighbour or anonymously, a written referral would not be expected but they could be offered a meeting to discuss the referral.

The relevant local referral process should be used. This may be a specific referral form and/or a telephone call. Check with local authority websites for details.

The matter can additionally be reported to the police where a crime is committed or suspected.

#### 2.4.1.1 Information

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

##### **Details of the referrer**

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

**Details of the adult at risk**

- Name(s), address and telephone number
- Date of birth, or age
- Details of any other members of the household including children
- Information about the primary care needs of the adult, that is, disability or illness
- Funding authority, if relevant
- Ethnic origin and religion
- Gender (including transgender and sexuality)
- Communication needs of the adult at risk due to sensory or other impairments (including dementia), including any interpreter or communication requirements
- Whether the adult at risk knows about the referral
- Whether the adult at risk has consented to the referral and, if not, on what grounds the decision was made to refer
- What is known of the person's mental capacity and their views about the abuse or neglect and what they want done about it (if that is known at this stage)
- Details of how to gain access to the person and who can be contacted if there are difficulties

**Information about the abuse, neglect or physical harm**

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

**Details of the person causing the harm (if known)**

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

**Any immediate actions that have been taken**

- Were emergency services contacted? If so, which?
- What action was taken?
- What is the crime number if a report has been made to the police?

- Details of any immediate plan that has been put in place to protect the adult at risk from further harm
- Have children's services been informed if a child (under 18 years) is a risk?

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

#### **2.4.1.2 Referrals to the police**

Staff must make it clear whether they are reporting a crime or suspected crime, or seeking advice. Referral must also be made to the relevant local authority.

In an emergency call the police on 999 or the Central Communications Command on 0300 123 1212. If a crime has been or may have been committed, report immediately to the police *unless* the adult at risk has mental capacity, does not want a report made and there are no overriding public or vital interest issues. The police may also be contacted later, if more information becomes available and it becomes apparent that a crime has been committed.

Currently arrangements for non-emergency referral/reports to the MPS vary across boroughs and reference should be made to local borough information.

#### **2.4.2 Receiving a referral and gathering the facts**

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

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

#### **Referrals to a MARAC**

If the concern indicates high-risk domestic violence, a referral should be made to MARAC. If the referrer does not have authority to refer to MARAC, this can be done by the SAM.

##### **2.4.2.1 Decision to accept as a Safeguarding Adults referral**

The following factors apply when making a decision to accept a referral:

- The adult at risk may not have the mental capacity to make decisions about their own safety

- The abuse or neglect has occurred on property owned or managed by an organisation with a responsibility to provide care
- The person causing the harm is:
  - > staff
  - > a volunteer(s)
  - > someone who only has contact with the adult at risk because they both use the service
- Other people are at risk from the person causing harm and they are also adults at risk.

In the above situations, action should be taken under the Safeguarding Adults procedures even if the adult at risk does not want any action taken. They should be informed of the decision, the reason for the decision and reassured that no actions will be taken which affect them personally without their involvement.

In other situations, for example, domestic violence, if, in consultation with relevant organisations, there is seen to be a high level of risk, a multi-agency strategy discussion or meeting may be held even if the adult at risk does not want any action taken. This would enable discussions around providing the adult at risk with support and signposting to relevant organisations, for example, Victim Support, counselling services and Safer Neighbourhoods.

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

Where there is concern that the adult at risk may not have mental capacity to make relevant decisions, it is important that their capacity is appropriately assessed as soon as possible. It may be established that with appropriate support, they are able to make their own decisions.

If it is established that the adult at risk lacks capacity, feedback will be given to them and anyone who is acting in their best interests, for example, their attorney or court-appointed deputy, unless they are implicated in the allegation.

If the person has no suitable family or friend who can be consulted regarding their best interests, an advocate or an IMCA should be instructed in line with the local IMCA referral policy. An IMCA may be instructed if it is felt that it will be beneficial to the adult at risk, even if they have family, friends and carers available to consult.

The SAM must ensure that contact is made with a carer or personal representative. The SAM will also decide in consultation with other relevant organisations what will be fed back at this point to the person causing the harm.

#### **2.4.2.2 If the adult at risk has capacity**

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

- find out from them what is happening
- talk to them about your concerns

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

#### **2.4.2.3 Deciding when not to use the Safeguarding Adults procedures**

It may be decided not to use the Safeguarding Adults procedures when there is enough information to decide that:

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

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

- adults with low-level mental health problems/borderline personality disorder
- older people living independently in the community
- adults with low-level learning disabilities
- adults with substance misuse problems
- adults self-directing their care.

Under adult social care eligibility guidance (DH 2010) published by the Department of Health, the position is as follows.

First, for people falling within the community care service user groups (as defined in legislation), a safeguarding concern will give rise to a duty on the local authority to assess that person under s.47 of the NHS and Community Care Act 1990.

Second, once an assessment has been carried out (or, in urgent cases, even before), and it is established that abuse or neglect has occurred or will occur, the person's need will – under the guidance – be 'critical' or 'substantial'. A legal obligation then arises to provide assistance, by way of community care services under one or more pieces of community care legislation.

If a decision is made not to follow the Safeguarding Adults procedures a record must be made with the reasons.

The referrer must also be informed of the decision in a timely way, the reasons for it and information given about any alternative services which have been offered, if this does not breach the adult's confidentiality.

The SAM will designate the most appropriate person to feed back to the adult at risk. This will often be the alerting manager or the alerter. Where the person does not have mental capacity, they should still be included in the process. Feedback will also be given to the person acting in their best interests, for example, their carer or court-appointed deputy.

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

The alerting manager must cooperate within the Safeguarding Adults process and play an active role in the decision. They should:

- take part in a strategy discussion or meeting if required
- communicate all the information they have about the potential risk
- be prepared to give advice about an interim protection plan and receive information about what action is planned
- provide the name of the alerter so that they can be contacted by the SAM
- find out from the SAM what they will do next and how and when they will be informed about what will be happening
- agree at this stage what they will tell the alerter and the adult at risk – if possible within the same working day.

If the alerting manager is the manager of the service where the adult at risk attends or where the abuse took place, they have particular responsibilities to:

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

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

#### **2.4.2.5 Supporting an adult at risk who makes repeated allegations**

An adult at risk who makes repeated allegations that have been investigated and are unfounded should be treated *without prejudice*.

- Each allegation must be responded to under these procedures
- A risk assessment must be undertaken and measures taken to protect staff and others and a case conference convened, where appropriate
- Each incident must be recorded
- Organisations should have procedures for responding to such allegations that respect the rights of the individual, while protecting staff from the risk of unfounded allegations.

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

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

#### **2.4.2.6 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 adult 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.

Should it be necessary as part of the investigation to arrange for a medical examination to be conducted, the following points should be considered:

- the rights of the adult at risk
- issues of consent and ability to consent
- the need to preserve forensic evidence
- the involvement of any family members or carers
- the need to accompany and support the adult at risk and provide reassurance and the identification of someone appropriate to do so (consider an advocate).

## **2.5 Stage Three: Strategy discussion or meeting**

This section covers:

- purpose of the strategy discussion or meeting
- who should attend
- roles and responsibilities
- possible outcomes
- recording and sharing information

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

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

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

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

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

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

### 2.5.1 Purpose of the strategy discussion or meeting

The purpose of the strategy discussion or meeting is:

- to agree a multi-agency plan to investigate the allegations and assess the risk to the person who is being harmed and address any immediate needs
- to coordinate the collection of information about the abuse or neglect.

The strategy discussion or meeting must:

- consider the wishes of the adult at risk
- agree whether an investigation will take place, and if so, how it should be conducted and by whom



- undertake risk assessment
- agree an interim protection plan
- make a clear record of the decisions
- record what information is shared
- agree an investigation plan with timescales
- agree a communication strategy
- consider whether a child (under 18 years) may be at risk
- circulate decisions to all invitees within five days using the appropriate pro forma

The strategy discussion or meeting should take place before any investigation. The commencement of a police investigation is an exception to this when vital evidence gathering is required. An organisation should not begin an investigation prior to a decision by the multi-agency strategy meeting or discussion.

#### **2.5.1.1 Deciding whether to hold a multi-agency strategy meeting**

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

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

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

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

#### **2.5.2 Who should attend**

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

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

Attendees may include:

- the manager of an adult social care team, an integrated/joint health and social care team, central Safeguarding Adults team or a CMHT if they are not the SAM
- the social services care manager or key worker if the case is known to them
- the care coordinator of the CMHT if the case is known to them
- the police, if there are concerns that a crime has been committed
- the person making the referral, if they are a professional
- the officer from the CQC in line with their Safeguarding Adults protocol with regard to registered care homes
- a health professional
- the IMCA or other advocate (if an IMCA has not been instructed a decision must be made as to whether to do so. An organisation which does not have authority to appoint an IMCA should discuss this with the SAM, who can ensure that one is instructed as necessary)
- other staff from adult social care who have a role to play/relevant involvement
- the manager of a provider service unless they are named in the allegation, in which case advice should be sought from the CQC as to who should attend
- a representative of the council legal department or client affairs officer
- a representative of any other organisation which has a role to play
- a child protection coordinator, if there are also child protection concerns
- the Safeguarding Adults lead for health
- a manager from a *Supporting People* housing organisation.

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

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

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

The police investigation could take some time and other organisations could have duties to take action. Agreement must be reached at the strategy stage, either in a strategy discussion or meeting between the police and other involved organisations about what actions they can take and when.

Any SAM who experiences difficulty in obtaining a police response to a referral or to an informal request for advice or who has any other concerns regarding a Safeguarding Adults investigation should refer their concerns to the relevant Safeguarding Adults lead to pursue through strategic multi-agency partnerships.

#### **2.5.2.1 Supporting the adult at risk**

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

#### **2.5.2.2 Supporting the person allegedly causing harm**

- Decide who will interview the person allegedly causing harm and/or give them information about the allegations (and when this should happen). This will usually be the interviewing officer of the organisation that has a duty to investigate
- If the person allegedly causing harm is a member of staff or a volunteer, confirm that the relevant regulatory authority has been informed. It is important to preserve the confidentiality at all times of all concerned including staff members under the Safeguarding Adults information-sharing protocols.
- The primary concern must be the safety of the adult at risk, but the person allegedly causing harm has a right to have information about any accusations and the process that will be followed.
- Decisions about notifying the person allegedly causing harm need to be made at the strategy meeting, weighing up potential repercussions or further risk of harm.
- If the person allegedly causing harm is also an adult at risk, a decision must be made about how their needs are to be met during the investigation. For example, if they lack capacity, they will also need someone who can represent them, possibly an IMCA
- Identify if the person needs advice, support, assistance or services under community care legislation.

- Throughout the Safeguarding Adults process, people alleged to have caused harm must be treated and spoken of without prejudice
- Cases where the person alleged to have caused harm is a family member, friend or carer need to be treated with particular sensitivity. For example, work may need to be done to make sure the person alleged to have caused harm understands what abuse is. A carer may also need a carer's assessment.

### 2.5.3 Roles and responsibilities

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

The organisation responsible for undertaking their part of the investigation should have regard to their other responsibilities or the legal powers, for example, employment law, criminal law and clinical governance. The person identified to undertake the investigation will be designated the 'investigating officer' for the purpose of the Safeguarding Adults process.

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

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

- If the situation indicates that the adult at risk is being subjected to domestic violence and the risks are high, agree a referral to MARAC. Designate the organisation and the person who will complete the MARAC risk assessment and make the referral. This can be done by the SAM. The MARAC process does not replace the Safeguarding Adults process, but adds benefit to any risk assessment.
- If the alert was made by a service user or a member of the public about abuse or neglect within an organisation, the organisation's complaints procedure could form part of the investigation and risk assessment. A decision will be made on a case-by-case basis as to whether the complaints process is suspended pending the outcome of another investigation.

## 2.5.4 Possible outcomes

### 2.5.4.1 Continuing the Safeguarding Adults process

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

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

- Whether the strategy will need to be reviewed during the investigation and risk assessment and make a date for that to happen.
- The timescale in which the investigation should take place. The investigation should begin as soon as possible after the strategy meeting or discussion and be completed within 20 days of the Safeguarding Adults referral.
- If, due to the complexity of the investigation, it is clear from the outset that a longer timescale will be required, this must be agreed at the strategy meeting or discussion by all relevant organisations and a record made of the decision
- In the above situation it may be necessary to hold a further strategy meeting to ensure that a review is made of protection arrangements
- A date for a case conference.

### 2.5.4.2 Investigations and processes that could be triggered by a referral

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

- a police investigation if a crime might have been committed
- an investigation by the CQC, if the concern arose in a regulated service
- an investigation under care management or the CPA
- an assessment of a carer's needs
- action by employers such as suspension and an investigation under disciplinary procedures if the concern indicates that the abuse or neglect was caused by a member of staff or paid carer
- investigation of a complaint by the complaints department of an organisation
- an investigation by the OPG if the concern is about an attorney created under a lasting or enduring power of attorney or a court-appointed deputy

- referral to the Court of Protection for a decision, declaration order or the appointment of a deputy
- an investigation by the Department for Work and Pensions if the concern is about the misuse of appointeeship or fraud in relation to benefits
- action for breach of contract terms
- a referral to MARAC where the allegation indicates domestic abuse and there is a high risk to the person
- an investigation into a situation where forced marriage could be indicated
- arrangements for the care and treatment of the person who is alleged to have caused the harm if they are also an adult at risk.

**Table 2.2: Type of investigation or risk assessment and agency responsible**

Type of investigation/risk assessment	Agency responsible
Criminal (including assault, theft, fraud, hate crime, domestic violence and abuse or wilful neglect of a person lacking capacity)	Police
Domestic violence – serious risk of harm	Relevant organisation carries out a MARAC risk assessment/MARAC referral
Fitness of registered service provider	CQC
Unresolved serious complaint in healthcare setting	CQC
Breach of rights of person detained under the Mental Capacity Act 2007 Deprivation of Liberty Safeguards (DoLS)	CQC
Breach of terms of employment/disciplinary procedures	Employer
Breach of professional code of conduct	Professional regulatory body
Breach of health and safety legislation and regulations	Health and Safety Executive (HSE)
Complaint regarding failure of service provision (including neglect of provision of care and failure to protect one service user from the actions of another)	Manager/proprietor of service/complaints department Ombudsman (if unresolved through complaints procedure)
Breach of contract to provide care and support	Service commissioner (eg social services, PCT, <i>Supporting People</i> )
Assessment of need for health and social care provision (service users and carers)	Social services/PCT/CMHT/care trust
Access to health and social care services to reduce the risk of abuse/neglect	Social services/PCT/CMHT/care trust
Misuse of enduring or lasting power of attorney or misconduct of a court-appointed deputy	OPG/Court of Protection/Police

Type of investigation/risk assessment	Agency responsible
Inappropriate person making decisions about the care and well-being of an adult at risk who does not have mental capacity to make decisions about their safety which is not in their best interests	OPG/Court of Protection
Misuse of appointeeship or agency	Department for Work and Pensions
Anti-social behaviour (eg harassment, and nuisance by neighbours)	MPS Community Safety Team
Breach of tenancy agreement (eg harassment, and nuisance by neighbours)	Landlord/registered social landlord/ Housing Trust/Community Safety Team
Bogus callers or rogue traders	MPS and Trading Standards officers

#### **2.5.4.3 Continuing action through other processes**

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

#### **2.5.4.4 No further action under the Safeguarding Adults procedures**

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

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

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

## 2.5.5 Recording and sharing information

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

- name of the adult at risk
- date and time of the meeting
- name and contact details of the SAM
- names and contact details of attendees
- details of the incident or the concern, with time, location and relevant details
- type(s) of abuse suspected
- an assessment of the seriousness/severity of harm
- consideration of the wishes of the person at risk
- name of the person causing harm (or alleged to have caused harm)
- whether there were any witnesses
- decisions made, including timescales and names and tasks of responsible people
- name(s) and contact details of the organisation(s) conducting the investigation
- name of the person(s) who will conduct the investigation
- name of the organisation that is contributing to the interim protection plan and what that contribution is
- details about any disagreements and how these will be resolved
- date for a strategy meeting review, if one is to take place
- date for the case conference.

Decisions of the meeting or discussion should be made available to participants at the meeting within 24 hours, and minutes of the meeting should be distributed within agreed timescales. Regard should be had to confidentiality and data protection issues.

Local partnerships may have their own standard agendas and templates for the structure of strategy meetings and discussions.

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

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

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

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



- undertaking a risk assessment
- devising a protection plan
- devising a treatment plan
- having in place a contingency safety plan
- making arrangements for monitoring and reviewing plans.

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

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

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

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

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

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

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

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

#### **2.5.5.3 Investigation by the organisation in which the concern has arisen**

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

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

If it is decided that an investigation will be undertaken by the organisation in which the concern arose, the manager within the organisation responsible for the investigation must ensure that:

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

#### **2.5.5.4 Resolution of disagreements**

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

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

## **2.6 Stage Four: Investigation**

This section covers:

- purpose of the investigation
- roles and responsibilities
- undertaking the investigation
- the investigator's report

## 2.6.1 Purpose of the investigation

The purpose of the investigation is to establish the facts and contributing factors leading to the referral. In addition there are responsibilities to identify and manage risk to ensure the safety of the individual and others. It should seek to clarify the views of the adult at risk, enable a mental capacity assessment to be carried out if required and instruct an IMCA if that is indicated.

### 2.6.1.1 Contributing to other lines of enquiry

The investigation may also contribute to:

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

### 2.6.1.2 Standard of proof

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

## 2.6.2 Roles and responsibilities

### 2.6.2.1 The investigating officer

A manager of the organisation who has responsibility to undertake an investigation will identify a member of staff to be the designated 'investigating officer' for the investigation.

The investigating officer should be a suitably qualified and experienced member of staff working under the supervision of a manager, who could be the Safeguarding Adults lead manager within the organisation. The investigating officer must not have line manager responsibilities for the person alleged to have caused harm, or work in the same department.

If there is a criminal investigation, the police will be the lead organisation and any other investigations must be coordinated with them.

### 2.6.2.2 Specific responsibilities of managers

- Effective supervision and ongoing support are essential for the investigating officer (the practitioner who is undertaking the investigation).
- The manager of the investigating officer must confirm the accuracy of all records relating to a Safeguarding Adults investigation, including:
  - > records of the initial investigation and assessment
  - > records of any decisions taken at strategy meetings or case conferences
  - > records of the investigation and interview(s) and
  - > a record of any decision taken to close the investigation
- If an investigation is being conducted within their organisation, the manager must ensure that a SAM is kept up to date with progress of the investigation and is provided with a report prior to the case conference
- The manager of the investigating officer should take all reasonable steps to ensure the health and safety of staff involved in a Safeguarding Adults investigation.
- A risk assessment of the situation should include consideration of the risks to the member of staff involved in the Safeguarding Adults investigation. Where the risk is assessed as being high, staff should not normally undertake a visit unaccompanied.
- The manager of the investigating officer must preserve the confidentiality at all times of all concerned including staff members under the Safeguarding Adults information-sharing protocols.

### 2.6.2.3 Responsibility of all organisations taking part in the investigation

Each organisation must designate a suitably trained and experienced member of staff to ensure that the organisation carries out its role and responsibilities in the plan agreed at the strategy meeting stage. This will include ensuring that the organisation carries out agreed actions including conducting the investigation, carrying out a risk assessment and implementing their part of the interim protection plan.

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

- actions to safeguard adults at risk are given top priority and they are supported throughout the process
- clear records are kept of any contact with, or actions taken to support or care for, the adult at risk
- there is support and supervision for staff carrying out this work
- the organisation actively cooperates with other organisations taking part in the investigation, risk assessment and Safeguarding Adults enquiry
- the SAM is kept up to date and informed of any new information or changes in the situation or the plan as soon as possible
- any agreed enquiries are conducted without delay
- clear records are kept of any enquiries or investigation findings which emerge about the circumstances of the Safeguarding Adults concerns
- a written report of the findings is prepared and sent to the SAM, which will form the basis of the organisation's input into the protection plan.

#### **2.6.2.4 Responsibilities to the adult at risk during the investigation**

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

- Address any communication needs
- Identify and take into account any equality issues
- Agree an interim protection plan with the adult at risk and ensure they know them and how they will be supported and kept informed during the investigation, including having an appropriate independent advocate
- Whether the person has mental capacity or not, they must be involved in the process as far as possible
- Carry out a risk assessment with the adult at risk if they have mental capacity
- Discuss issues of confidentiality and information sharing with the adult at risk and if there are no others at risk, get permission to share information with other organisations as required. If there are others at risk, inform the adult at risk of the duty to share information to protect others
- If the person at risk has mental capacity, reassure them that no decisions or plans which have an impact on their daily living arrangements will be made without their agreement to that decision
- If the police are the lead investigating organisation, they will conduct interviews in a way to achieve best evidence under the provisions of the Youth Justice and Criminal Evidence Act 1999
- If there are grounds for prosecution, the CPS should consider the need for an application to be made to the court for special measures under the above legislation
- If during the investigation it becomes clear that the situation indicates domestic violence and there is a high risk of harm, a referral should be made to MARAC. If the organisation conducting the investigation cannot make such a referral they should refer to the SAM, who will complete the MARAC risk assessment and refer
- If the person at risk does not have mental capacity to make decisions about their safety, the investigating officer must continue to involve them. They must also consult with their personal representative, a court-appointed deputy or attorney, if they are not implicated in the allegation and/or an IMCA if one has been instructed
- During the investigation the investigating officer should keep the relevant SAM informed of the progress of the investigation and of any information that could impact on the continued safety of the person at risk or others who may be at risk and indicate changes that are needed to the interim care plan
- If the investigation is likely to be prolonged, another strategy meeting must be held to ensure that the interim protection plan is providing adequate safeguards for the adult at risk (and other individuals at risk if necessary)
- If the investigation reveals that a child or young person is living in the same household and could be at risk, referral should be made immediately to the relevant children and families service.

### 2.6.3 Undertaking the investigation

#### 2.6.3.1 Timescales

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

The investigation should be implemented without any reasonable delay and should be completed within 20 working days of the referral.

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

### 2.6.4 The investigating officer's report

The investigating officer should:

- send the report of the investigation to the SAM within 20 days of the alert being raised or as agreed at the strategy meeting to be copied for distribution to relevant organisations. The report will form the basis of the discussion at the case conference
- keep personally identifiable information concerning the adult at risk, the person causing the harm and any third parties to a minimum
- share the report only with organisations who have a need to know in order to safeguard the adult at risk, to inform the protection plan and to inform what action will be taken against the person causing the harm if the allegation is substantiated.

On receiving the report the SAM will ensure a case conference is convened within five days to bring together the findings, and will look at the:

- complexity of the situation
- number of organisations involved
- seriousness of the allegation
- levels of risk to the individual
- risk to others.

## 2.7 Stage Five: Case conference and protection plan

This section covers:

- purpose of the case conference
- who should attend
- Part 1: The investigation findings
- Part 2: The protection plan

- other possible outcomes of the case conference
- recording and feedback

### 2.7.1 Purpose of the case conference

The aim of a case conference is to:

- 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 protection plan
- agree how the protection plan will be reviewed and monitored.

To help support the attendance and effective participation of the adult at risk, it is recommended that the case conference be divided into two parts:

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

Alternatively, if it is necessary in order to meet the adult at risk's access and communication needs (if specialist facilities are needed), a separate protection 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.

#### 2.7.1.1 Planning the meeting

The case conference should take place within 5 working days from receipt / distribution of the safeguarding investigation report (or as agreed at strategy discussion or meeting). Some investigations and outcomes or processes may not be completed within this time frame, for example, a criminal prosecution, but the case conference should not be delayed because it is essential that a protection plan is put in place as appropriate.

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

The representative from the organisation that carried out the investigation and risk assessment who will attend the case conference should submit a report summarising the findings of the investigation. The report should be sent to the SAM prior to the meeting and will be copied to all attendees.

## 2.7.2 Who should attend

### 2.7.2.1 Attendance of the adult at risk at Part 2 of the case conference

The adult at risk should be:

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

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

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

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

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

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

### 2.7.2.2 Others attending the meeting

- Carers should only be invited to the meeting on the express wish of the person at risk. If the adult does not have the mental capacity to make that discussion, it may be made in their best interests, or with the consent of an attorney or deputy
- The person causing the harm should not attend the meeting unless it is part of the protection plan to change their behaviour and reduce abuse or neglect and the adult at risk has given explicit consent. If the meeting decides there are actions to be taken with regard to the person causing the harm, the meeting must decide who will inform them of the actions and the reasons why this decision was taken



- Each organisation involved in the investigation should send a suitably qualified and experienced manager to the case conference and protection planning meeting. This will usually be the person who undertook the investigation in the organisation and may be the manager or the Safeguarding Adults lead
- The manager of the organisation who conducted the investigation and risk assessment
- The investigating officer
- The manager of any other organisation who can contribute to the protection plan
- Another member of staff from the organisation that has conducted the investigation, as above
- The care manager or care coordinator or key worker for the adult at risk
- Other relevant professionals, for example, the police, GP, psychiatrist or other healthcare involved with the adult at risk
- A representative from the legal department may also need to be invited.

If a professional is unable to attend, they must provide relevant information to the meeting.

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

### 2.7.3 Part 1: The investigation findings

The meeting will:

- receive and consider the information contained in the investigating officer's report and decide what further action is/may be needed
- make a decision about current levels of risk and make decisions about the reduction of future risks
- 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).

#### 2.7.3.1 Deciding the outcome

The purpose of the case conference is to evaluate the evidence and to determine the outcome on balance of probability. The NHS Information Centre for Health and Social Care identifies four possible outcomes that are:

- substantiated
- partially substantiated
- not substantiated

- not determined/Inconclusive.

It is also to ensure the protection plan is still relevant and appropriate.

#### **Possible outcomes for the adult at risk**

- Increased monitoring
- Removal from property/support, advice, services
- Assessment/services
- Application to Court of Protection
- Application to change appointeeship
- Referral to advocacy service
- Referral to counselling services
- Guardianship/use of Mental Health Act 2007
- Review of self-directed support
- Restriction/management of access
- Referral to MARAC
- No further action
- Other

#### **Possible outcomes for the person alleged to have caused harm**

- Criminal prosecution/formal caution
- Police action
- Assessment/services
- Removal from property/support, advice, services
- Management of access to adult at risk
- Referral to ISA
- Referral to regulatory body
- Disciplinary action
- Action by CQC
- Continued monitoring
- Counselling/training
- Referral to court-mandated treatment
- Referral to MAPPA
- Action under Mental Health Act 2007
- Action by contract compliance
- Exoneration
- No further action
- Other

### **2.7.4 Part 2: The protection plan**

The meeting will:

- agree a protection plan with the adult at risk (or the person representing them or their best interests) and decide which organisation will monitor and coordinate the plan
- agree contingency actions if the protection plan does not work

- designate a protection plan coordinator (this is likely to be different to the role of the SAM, for example, the adult at risk's named social worker may undertake this role)
- agree how the protection plan will be shared with partners, taking into account information-sharing considerations
- provide support and services to meet the needs of the adult at risk and of a carer, if that is indicated
- determine what additional information needs to be shared and with whom
- 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. If this is the decision reached, the reporting mechanism for the outcome of the review needs to be established and agreed (for example, information sent to the chair or the SAM following the review)
- if there are concerns that the protection 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 protection plan will not include actions taken against the person causing harm.

### 2.7.5 Other possible outcomes of the case conference

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

- Implementation of changes following an organisational review, for example, staffing, recruitment, policies, procedures, training, working practice and culture. This may include planned changes (training etc) relating to the individual staff members
- Implementation of requirements made in recommendations from a complaints process (including an action plan/timetable for implementation)
- Review of personal budget arrangements for someone who directs their own care
- Improvement of risk monitoring and quality assurance measures
- Referral to the ISA.

A referral to the ISA must be made by the regulated activity provider:

- if they have withdrawn permission for the person (a member of staff or volunteer) to engage in regulated or controlled activity, or would have done so if the person had not resigned, retired, been made redundant or been transferred to a position which is not a regulated or controlled activity and
- if they think the person has:
  - > engaged in relevant conduct or
  - > satisfied the harm test (that is, they have harmed or put at risk of harm the adult at risk).

### 2.7.5.1 Requirements by other bodies

Such requirements may include:

- implementation of requirements by the appropriate regulator, for example, the CQC
- implementation of requirements made by the commissioner of the services, for example, adult services, the PCT, *Supporting People*
- instigation of a serious case review or serious incident process if there are concerns about the Safeguarding Adults process and/or inter-agency working by the SAPBs.

### 2.7.5.2 Action by other bodies

This may include:

- suspension of a contract by a commissioner, for example, adult services, the PCT, *Supporting People*
- a commissioner ending a contract or a relationship with a provider
- deregistration by the CQC
- prosecution of company directors
- referral to a relevant professional body.

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

Following the investigation:

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

## 2.7.6 Recording and feedback

### 2.7.6.1 Case conference minutes

Minutes should be recorded on the relevant local authority or agreed multi-agency pro forma and approved by the chair of the meeting. The minutes record the

decisions of the case conference and evidence of how the decisions were made. This may involve recording separate decisions and outcomes for each allegation.

The minutes should be circulated within five working days of the case conference to:

- the alerting manager and the protection plan coordinator
- all attendees and invitees to the meeting
- all those contributing to the protection plan
- the CQC where the case conference relates to a service that it regulates
- all other relevant regulatory bodies, as appropriate.

Unless it would increase the levels of risk, a copy should be sent to the adult at risk or, with their permission, to another person. If the adult at risk does not have mental capacity, a decision should be made in their best interests about who to send the minutes to.

Where there is information that cannot be shared, it should be deleted from versions of documents sent out. It is imperative that Data Protection Act 1998 principles are adhered to.

Where information is sent to a carer, with permission of the adult at risk or in their best interests, the SAM will decide what information can be shared about the person causing the harm.

Whether or not minutes of the meeting are sent to the adult at risk, the SAM will decide who is the best person to feed back to them the outcome of the meeting. This should take place as soon as possible after the meeting. The adult at risk should be enabled to raise any issues they may have about the decisions taken and the protection plan that has been developed/agreed on.

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

#### **2.7.6.2 Feedback to the person causing the harm**

The person causing the harm has a right to know about the referral and the reasons for it at a time that will not compromise the investigation or protection plan.

A decision must be made in the meeting about what feedback should be provided to the person causing harm and the organisation that employs the person if relevant, and who should provide it.

If the person causing the harm does not have mental capacity (and is also an adult at risk), feedback will be given to the person acting in their best interests.

#### **2.7.6.3 Deciding to hold a separate protection plan meeting**

Normally a protection plan will be agreed as part of the case conference. A separate protection plan meeting may be considered necessary if:

- the strategy meeting decided that it was possible to move to agreeing a protection plan without a formal investigation and case conference
- the investigation was complex or lengthy and there were confidentiality issues which would mean the adult at risk being absent for a significant part of the meeting. Their interests would then be best served by having a separate meeting that they could attend
- there are clinical considerations regarding the person's ability to engage in the process at a given time as agreed by the agencies concerned
- the protection plan meeting needs to take place in the person's own home or in another setting because of access reasons.

Supporting the person to make decisions about what can be done to help them will mean that they are given information about:

- the process and the organisations that may be involved
- the actions that organisations may be or are able to take
- which organisations may be able to offer support
- what the risks may be from not taking any action.

The individual should also be offered the possibility of:

- receiving emotional support if necessary
- taking part in activities which increase their ability to protect themselves
- making contact with a named organisation if they change their mind about the protection plan, or if they indicate that they do not wish any further involvement with the Safeguarding Adults process at this time and later change their views about this or the abuse gets worse and they want help to reduce the risk of further harm.

#### **2.7.6.4 If the adult at risk moves during the Safeguarding Adults process**

The SAM must:

- ensure that action is taken to ascertain their whereabouts and their safety/well-being
- notify the new local authority, in writing, of action taken under the Safeguarding Adults process and what action remains outstanding. The new local authority area needs to agree to the case transfer, if this is what is being requested
- send fully documented and relevant information and summaries as appropriate
- reach agreement with a senior manager or SAM in the new local authority about future action and roles and responsibilities. Acknowledgement of receipt of the information should be obtained in writing.

Other organisations that have been involved in the investigation must also be advised if the adult at risk has moved to another area.

If an adult at risk moves to a residential or nursing home outside the local borough, and the local borough retains financial responsibility, they should liaise with the

host local authority. If appropriate, the protection plan will be incorporated into the residential care plan. In this case the funding authority retains a duty of care.

Special rules apply to adults who are subject to Section 117 of the Mental Health Act 1983 (aftercare). Where this applies, the mental health service in the original borough retains responsibility for the patient until this responsibility is accepted by the mental health services of the new area.

In some cases family, friends or carers may remove an adult from the UK before a full investigation can be carried out and protective measures put in place. If there is any indication that such a removal is being planned, legal advice must be sought urgently. If removal does occur, legal guidance must still be sought.

#### **2.7.6.5 If the person causing the harm moves during the Safeguarding Adults process**

If the person causing the harm is a paid worker or a volunteer, their situations are covered by the provisions of the Safeguarding Vulnerable Groups Act 2006.

Regulated activity providers are now under a duty to make referrals to the ISA of the names of staff and volunteers who have been found to have harmed or put at risk of harm a child or a 'vulnerable' adult. This includes the names of those who would have been dismissed because they harmed or put at risk of harm a child or a vulnerable adult.

The ISA will make a judgement on the evidence whether the person should be barred from any future employment or activity with adults at risk.

For guidance on referral processes to the ISA, see [www.isa-gov.org](http://www.isa-gov.org)

A person who is barred from working with adults at risk and/or children and who seeks such employment commits an offence punishable with up to five years' imprisonment. An employer is also committing an offence if they knowingly employ someone who is barred from such employment.

Where a police investigation is already under way, it will continue even if the person causing harm moves away.

#### **2.7.6.6 If a referral or complaint is received after an adult at risk has died**

The referral or complaint could contain an allegation or suspicion that 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 will be undertaken.

### 2.7.6.7 If the adult at risk dies during the Safeguarding Adults process

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

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

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

Following the death of a person, more than one investigation into the circumstances surrounding the death may need to be instigated because more than one organisation may have been involved with the individual. A strategy meeting of relevant organisations should be convened to review the allegation or complaint and to agree a coordinated investigation. If there is to be a police investigation, that investigation will take primacy. As with any other safeguarding situation giving rise to action under the Safeguarding Adults procedures, there is an expectation that all organisations will cooperate in the agreed process.

The Coroner will be informed by the police of the death as soon as possible (and before burial or cremation) if abuse or neglect is suspected to be a contributory factor, that is, if it is thought that the death was not a natural death.

In either of the above situations, consideration should be given to whether there should be an independent manager's review or a serious case review to examine the circumstances involved.

## 2.8 Stage Six: Review of the protection plan

This section covers:

- purpose of the review
- who should attend
- actions
- recording and feedback

### 2.8.1 Purpose of the review

The purpose of the review is to ensure that the actions agreed in the protection plan have been implemented and to decide whether further action is needed, including any service improvements.

If a date for a review of the protection 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 adult at risk has 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 protection plan
- as the result of a request by the person coordinating the protection plan.

If a decision is taken at the case conference that a review is not thought to be necessary, the Safeguarding Adults process will be closed. In this case a decision can be taken that the protection plan should be reviewed as part of the ongoing care management or CPA processes.

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

### 2.8.2 Who should attend

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

The adult at risk should be enabled to participate in the review on the same basis as for the case conference.

In certain circumstances it may be beneficial to hold the review in the adult at risk's home.

The attendance at the review of a carer or a personal representative would be on the same basis as their attendance at the case conference.

### 2.8.3 Actions

The review should:

- review risk assessment
- decide about ongoing responsibility for the protection plan
- decide in consultation with the adult at risk or their personal representative what changes, if any, need to be made to the protection plan to decrease the risk or to make the plan fit more closely with their wishes
- record the feedback of the adult at risk or their personal representative about the protection plan and/or other matters of importance to them
- make decisions about what changes/additions are needed to the care plan
- decide whether there is need for a further review and, if so, set a date
- decide whether to close the Safeguarding Adults enquiry/processes.

#### 2.8.4 Recording and feedback

- Record any decisions and actions with the names of those organisations and individuals who have a role to play in the protection plan and who have been undertaking actions agreed during the review
- Ensure that all those involved in the review and the care plan have a copy of the review notes, including the adult at risk or their personal representative if the adult at risk gives them permission
- Reach agreement about feedback arrangements during the review in accordance with the adult at risk's best interests if they do not have mental capacity and do not attend the review. This feedback should be provided as soon as possible after the review meeting.

### 2.9 Stage Seven: Closing the Safeguarding Adults process

This section covers:

- when to close the Safeguarding Adults process
- actions on closing
- evaluation and learning
- record keeping and confidentiality
- monitoring

#### 2.9.1 When to close the Safeguarding Adults process

The Safeguarding Adults process may be closed at any stage if it is agreed that an ongoing investigation is not needed or if the investigation has been completed and a protection 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 protection plan review.

The SAM must reach agreement to close the process with all organisations that have been involved in the investigation and protection plan. The closing process must be signed off by the SAM and/or a senior manager in the case of a serious/complex Safeguarding Adults situation.

#### 2.9.2 Actions on closing

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

- all actions are completed or are in progress
- all records are completed
- case records contain all relevant information and satisfactorily completed forms
- the person at risk knows that the process is concluded and where/who to contact if they have any future concerns about abuse
- all those involved with the person know how to re-refer if there are renewed or additional concerns

- if proven, action to remove a member of staff from a professional register or refer to the ISA
- all evidence and decisions are adequately recorded
- referral is made to appropriate professional bodies where necessary
- notifiable occupation schemes are informed
- the referrer is notified of completion
- all relevant partner organisations are informed about the closure
- the necessary monitoring forms and all data monitoring systems are completed.

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

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

Through the SAPB, any partner agency can request that a case review, serious case review or independent management review is undertaken if there was a near-miss or a fatality, and procedures do not appear to have been followed or agencies did not work together effectively.

A serious case review or independent management review could also be indicated where the adult at risk disagreed strongly with the outcome of the investigation and provisions of the protection plan.

#### **2.9.2.1 When other processes continue**

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

### **2.9.3 Evaluation and learning**

The SAM will ensure that:

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

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

## 2.9.4 Record keeping and confidentiality

Organisations will have their own recording systems for keeping comprehensive records whenever a concern is made/arises/occurs, and of any work undertaken under the Safeguarding Adults procedures, including all alerts received and all referrals made.

Organisations should refer to their own internal policies and procedures for additional guidance on recording and storage of records.

Throughout the Safeguarding Adults process, detailed factual records must be kept. This includes the date and circumstances in which conversations and interviews are held and a record of all decisions taken relating to the process.

Records may be disclosed in court as part of the evidence in a criminal action/case or may be required if the regulatory CQC authority decides to take legal action against a provider.

Records kept by providers of services should be available to service commissioners and to regulatory authorities.

Agencies should identify arrangements, consistent with the principle of fairness, for making records available to those affected by, and subject to, investigation with due regard to confidentiality.

### 2.9.4.1 Keeping a local authority Safeguarding Adults file for adults at risk

It is good practice to keep a separate module/section in the client's file for all records relevant to the Safeguarding Adults process. This will ensure ease of access to information and enables information to be accumulated. This is particularly valuable where there may be a series of 'low-level' concerns that, over time, may reveal a pattern of repeating, and possibly escalating, events.

The Safeguarding Adults record will include all assessments, risk assessments, reports from other organisations, records of meetings and any decisions taken in the course of the Safeguarding Adults process. This section of the file should be arranged in chronological order.

### 2.9.4.2 If the person causing the harm is also an adult who uses the service or is also an adult at risk

The information about that person's involvement in a Safeguarding Adults investigation, including the outcome of the investigation, should be included in their records. If an assessment is made that the individual still poses a threat to other service users, this must be included in any information passed on to service providers.

Where the person causing harm is living within a care setting or supported living unit, the impact of their actions on the environment for other residents should be taken into account.

### 2.9.5 Monitoring

The CQC inspection regime includes an organisation's performance and compliance with Safeguarding Adults outcomes contained in CQC 'Guidance about compliance: Essential standards for quality, Outcome 7: Safeguarding people who use services from abuse'.

The NHS Information Centre for Health and Social Care requires that local authorities collect information about various aspects of Safeguarding Adults relating to details of the victim, the alleged person causing harm and the alleged offence and outcomes. This information is collated, and a return of data collection exercise is made on an annual basis to the Information Centre.

Local partnerships should also ensure that there is an agreed process for, and resources allocated to, collecting, processing and monitoring information relating to all Safeguarding Adults work undertaken within the procedures. All data concerning alleged abuse or neglect that an authority receives (that does not identify individuals) must also be collected and collated. All data collected will contribute towards policy development and service audit, and will also be a factor in the development of forward plans for service development, information/publicity work and training.

In most local authorities quarterly monitoring reports are required by the SAPBs. The collection and collation of these reports is overseen by the Safeguarding Adults coordinator or a relevant member of staff from the Safeguarding Adults team. Information from these reports informs the annual development and training plan which is produced by the SAPB.

### 2.9.6 Large-scale investigations, service-level concerns and serious case reviews

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

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

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

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

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

It is important that all aspects of the investigation are planned and the organisations and individual professionals are clear about their respective roles and responsibilities.

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

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

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

The Safeguarding Adults coordinator of the local authority should also be informed.

## Further reading

- ACPO (2004) *Guidance on investigating domestic abuse*, London: ACPO.
- ADSS (Association of Directors of Social Services) (2004) *Protocol for inter-authority investigation of vulnerable adult abuse*, London: ADSS.
- ADSS (2005) *Safeguarding Adults: A national framework of standards for good practice and outcomes in adult protection work*, London: ADSS.
- ADSS (2007) *Vulnerable adult serious case review guidance – Developing a local protocol*.
- CQC (Care Quality Commission) (2010) *Our safeguarding protocol: The Care Quality Commission's commitment to safeguarding*, CQC.
- DH (Department of Health) (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, London: DH.
- DH (2001) *Fair Access to Care Services (FACS): Guidance on eligibility criteria for adult social care*, London: DH.
- DH (2006) *Memorandum of understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm*, London: DH.
- DH (2010) *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care. Guidance on eligibility criteria for adult social care, England 2010*, London: DH.
- DH (2010a) *Liberating the NHS*, White Paper, London: DH.
- DH (2010b) *Clinical governance and Adult Safeguarding: An integrated process*, London: DH.
- GSCC (General Social Care Council) (2002) *Codes of practice for social care workers and employers*.
- Home Office (2009) *Handling cases of forced marriage*, London: Home Office.

## Protecting adults at risk

### London multi-agency policy and procedures to safeguard adults from abuse

*Protecting adults at risk* represents the commitment of organisations in Greater London to work together to safeguard adults at risk. The procedures aim to make sure that:

- the needs and interests of adults at risk are always respected and upheld
- the human rights of adults at risk are respected and upheld
- a proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse
- all decisions and actions are taken in line with the Mental Capacity Act 2005.

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