<table>
<thead>
<tr>
<th>Sheffield Care Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Wellbeing</td>
</tr>
<tr>
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<td>Sheffield Primary Care Trust</td>
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<tr>
<td>NHS</td>
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<tr>
<td>National Probation Service</td>
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<tr>
<td>Barisley Safeguarding Adults</td>
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<tr>
<td>Barnsley NHS</td>
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<tr>
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<tr>
<td>Primary Care Trust</td>
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<table>
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<tr>
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<td>Primary Care Trust</td>
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<table>
<thead>
<tr>
<th>Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust</th>
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<td>G Fairfield</td>
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<table>
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<tr>
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<tr>
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<thead>
<tr>
<th>Doncaster Metropolitan Borough Council</th>
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<tbody>
<tr>
<td>Domestic Violence Working Party</td>
</tr>
<tr>
<td>The Hesley Group</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Enhancing Lives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rotherham Metropolitan Borough Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham Primary Care Trust</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Rotherham NHS Foundation Trust</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Yorkshire Ambulance Service NHS Trust</th>
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</thead>
</table>
Safeguarding Adults

South Yorkshire’s Adult Protection Procedures

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[to be defined and completed by each Local Authority area]

Practice Guidance for local arrangements
SECTION 1 – INTRODUCTION and GOVERNING PRINCIPLES

1.1 Introduction
1.1.1 This document updates and supersedes the Adult Protection Procedures used across South Yorkshire, incorporating the local authority areas of Barnsley, Doncaster, Rotherham and Sheffield. These new arrangements will provide consistent countywide arrangements.

1.1.2 They are based on the guidance contained within ‘No secrets’ [DH 2000] and the Standards in ‘Safeguarding Adults’ [ADSS 2005]. In essence, these set out the process of a multi-agency agreement for Safeguarding Adults.

1.1.3 Safeguarding Adults work means all activity, which enables an adult to retain independence, well-being and choice and to be able to live a life that is free from abuse and neglect. It is about preventing abuse and neglect, as well as promoting good practice for responding to concerns on a multi-agency basis.

1.1.4 Safeguarding Adults work will potentially include the involvement of a broad range of organisations, service areas and workers, all of whom will need to be aware of their roles and responsibilities, on both an internal and multi-agency basis.

1.1.5 Previous references to the ‘Protection of ‘Vulnerable Adults’ and to ‘Adult Protection’ work will be replaced by the new term: ‘Safeguarding Adults’.

1.2 Endorsement
1.2.1 Each of the four local authority areas has a Safeguarding Adults Board, which oversees multi-agency work aimed at protecting and safeguarding vulnerable adults. The Board comprises people from partner organisations who have the ability to influence decision making and resource allocation within their organisation.

1.2.2 The role of the boards is to:
• ensure the effective implementation of multi-agency procedures
• audit and review practice at regular intervals
• guide the actions of all those involved in safeguarding vulnerable adults and
• make decisions about when Serious Case Reviews are held [see section 2.14 and Appendix 5].

1.2.3 The White Paper ‘Our Health, Our Care, Our Say’ [DH 2006] confirmed the leadership role in ‘well-being, improving commissioning and joint working’ through defining and strengthening the roles of Directors of Public Health (DPHs) and Directors of Adult Social Services (DASSs).
1.2.4 These policy and procedures have been agreed and endorsed by the Executive Directors of all partner agencies and safeguarding boards within in all four local authorities and confirms the high priority given to safeguarding, in that partners will:

- do everything within their power to ensure the Safeguarding of Adults within the context of ‘No Secrets’ [DH 2000] and the Standards contained within ‘Safeguarding Adults’ [ADSS 2005]
- support staff and volunteers who raise concerns
- commit to providing training and development opportunities for all staff to support them in their safeguarding responsibilities, as outlined in the inter-agency procedures.

1.2.5 This document is live and will be reviewed annually by the South Yorkshire Safeguarding Adults Co-ordinators’ group. Comments are welcomed and should be made to any of the Safeguarding Adults Co-ordinators:

<table>
<thead>
<tr>
<th>Barnsley</th>
<th>Doncaster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellington House</td>
<td>Scarborough House</td>
</tr>
<tr>
<td>36 Wellington Street</td>
<td>Chequer Road</td>
</tr>
<tr>
<td>Barnsley S70 1WA</td>
<td>Doncaster DN1 2DB</td>
</tr>
<tr>
<td>01226 775832</td>
<td>01302 736296</td>
</tr>
<tr>
<td>[email] barnsley.gov.uk</td>
<td><a href="http://www.doncaster.gov.uk/adultprotection">www.doncaster.gov.uk/adultprotection</a></td>
</tr>
<tr>
<td></td>
<td>[email] doncaster.gov.uk</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rotherham</th>
<th>Sheffield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crinoline House</td>
<td>Redvers House</td>
</tr>
<tr>
<td>Effingham Square.</td>
<td>Union Street</td>
</tr>
<tr>
<td>Rotherham S65 1AW</td>
<td>Sheffield S1 2JQ</td>
</tr>
<tr>
<td>01709 382121</td>
<td>0114 273 6870</td>
</tr>
<tr>
<td></td>
<td>[email] sheffield.gov.uk</td>
</tr>
</tbody>
</table>

1.3 Multi-Agency working in Safeguarding Adults

1.3.1 It is vital for the successful Safeguarding of Adults that the procedures in this document are understood and applied consistently by all organisations.

1.3.2 Although the responsibility for co-ordination of Safeguarding Adults arrangements lies with ‘Councils with Social Services Responsibilities', the operation of procedures is a collaborative responsibility.

1.3.3 Effective work must be based on a multi-agency approach, with decisions made as to the most appropriate organisation to be the lead agency in the safeguarding assessment, and who is the most appropriate person to undertake the roles described below.

1.3.4 Organisations working with vulnerable adults need to identify the roles and responsibilities appropriate to their own application of the procedures, and to work within any specific guidance provided. This includes the referral of issues of abuse or neglect into Safeguarding Adults processes.
1.3.5 For advice, guidance or clarification regarding Safeguarding Adults work, contact your local Safeguarding Adults Co-ordinator [see section 1.2.5].

### 1.4 Key Roles in Safeguarding Adults

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alerter</td>
<td><strong>Anyone</strong> who has contact with vulnerable adults and hears disclosures or allegations, or has concerns about potential abuse or neglect has a duty to pass them on appropriately. The alerter may also be the service user or a member of the public. The alerter also has a role in addressing any immediate safety or protection needs.</td>
</tr>
<tr>
<td>Referrer</td>
<td>Organisations will identify <strong>people responsible for referring</strong> concerns to either their own safeguarding managers or to referral agencies [police or ‘councils with social services responsibilities’]. Referrals may also be made directly by the service user, family or friends, or by a member of the public.</td>
</tr>
</tbody>
</table>
| Safeguarding Manager          | **A named person** [usually from statutory agencies in Health or Social Care] who is responsible for overseeing the Safeguarding Assessment and its outcome, including:  
• making decisions on the need to investigate, or identifying alternative responses  
• consulting the police regarding all safeguarding incidents, unless it is clear that no crime has been committed  
• convening and chairing strategy meetings, including the agreement of responsibilities, actions and timescales  
• co-ordinating and monitoring investigations  
• overseeing the convening of Safeguarding Case Conferences  
• providing information about activity and outcomes to Safeguarding Adults Co-ordinators. |
| Investigator                  | **Relevant practitioners** from Health & Social Care and the Police, who will co-ordinate the collection of the information about the alleged abuse or neglect. This may also include the use of criminal and/or disciplinary investigations. The investigator will form a view about whether abuse has taken place and what may be in an effective safeguarding plan and then present this in a report to a safeguarding case conference. |
| Safeguarding Adults Co-ordinator | **A senior manager**, accountable to the Safeguarding Adults Board for:  
• supporting the safeguarding assessment process by giving advice and procedural guidance  
• keeping a central record of all safeguarding activity in line with National Reporting Requirements  
• identifying multi agency practice issues to be addressed by the Safeguarding Adults Board members, including recommendations for education and training. |
### 1.5 Responsibilities in Safeguarding Adults

<table>
<thead>
<tr>
<th>Type of investigation or assessment</th>
<th>Agency Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal (including, assault, theft, fraud, hate crime and domestic violence, bogus officials, wilful neglect)</td>
<td>Police</td>
</tr>
<tr>
<td>Fitness of a registered provider or manager under the Care Standards Act 2000</td>
<td>Commission for Social Care Inspection</td>
</tr>
<tr>
<td>Breach of service regulations relevant to the service</td>
<td>Commission for Social Care Inspection</td>
</tr>
<tr>
<td>Unresolved serious complaint in a health setting</td>
<td>Health Care Commission</td>
</tr>
<tr>
<td>Breach of rights of person detained under The Mental Health Act</td>
<td>Health Care Commission</td>
</tr>
<tr>
<td>Breach of terms of employment or disciplinary procedures</td>
<td>Employer</td>
</tr>
<tr>
<td>Breach of professional code of conduct</td>
<td>Professional Regulatory Body</td>
</tr>
<tr>
<td>Breach of Health and Safety Legislation</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>Complaint regarding failure of service (including neglect of provision of care and failure to protect one service user from the actions of another)</td>
<td>Service provider, such as a manager or proprietor of service or complaints department</td>
</tr>
<tr>
<td>Breach of contract to provide care</td>
<td>Service commissioner</td>
</tr>
<tr>
<td>Bogus callers or rogue traders</td>
<td>Trading Standards Officers</td>
</tr>
<tr>
<td>Misuse of Enduring Power of Attorney</td>
<td>Office of the Public Guardian</td>
</tr>
<tr>
<td>Misuse of appointeeship or agency status in dealing with DWP administered benefits</td>
<td>Department of Work and Pensions</td>
</tr>
<tr>
<td>Inappropriate decisions about the care and wellbeing of an adult without mental capacity which are not in the adult’s best interests</td>
<td>Court of Protection</td>
</tr>
<tr>
<td>Assessment of need for health and social care provision (service users and carers).</td>
<td>‘Councils with Social Services responsibilities’, or health trusts.</td>
</tr>
</tbody>
</table>

### 1.6 Dealing with Disagreements and Complaints

1.6.1 Safeguarding Adults should be a collaborative process. It is hoped that in most circumstances inter-agency disagreements can be prevented or resolved through effective communication and open dialogue between organisations.

1.6.2 Every effort should be made by Safeguarding Managers, Safeguarding Adults Co-ordinators and Safeguarding Adults Partnerships to resolve complaints. If this is not possible, the relevant departmental complaints procedure should be
used following the resolution of the safeguarding concern, unless the complaint process can be discussed at the safeguarding strategy stage.

1.7 Governing Principles
1.7.1 Human Rights
1.7.1.1 There is a duty placed on public agencies under the Human Rights Act (1998) to intervene to protect the rights of citizens. These rights include Article 2 ‘the Right to Life’; Article 3 ‘Freedom from torture’ (including humiliating and degrading treatment); and Article 8 ‘Right to family life’ (one that sustains the individual).

1.7.1.2 Intervention should not be arbitrary or unfair, must have a basis in law and be necessary to fulfil a pressing social need e.g.
   - acting with the consent of the adult or,
   - under a duty of care, acting in the best interest of the adult or undertaken to secure a legitimate aim (i.e. to prevent a crime or protect the public).

1.7.2 Capacity
1.7.2.1 In accordance with the Mental Capacity Act 2005, we work from a presumption of mental capacity unless a person’s apparent comprehension of a situation gives rise to doubt.

1.7.2.2 It is the right of adults who have capacity to make their own choices, irrespective of how unwise we consider that decision to be. However, where:
   - a crime is suspected or
   - allegations involve a member of staff, paid carer or volunteer, or
   - there is a risk of serious harm to that person or any other vulnerable adults, then relevant agencies should be informed and allegations must be investigated, whether the alleged victim is willing to take an active part in the process or not.

1.7.2.3 Where adults lack the capacity to safeguard themselves, other people will need to make those decisions. In doing so they will act as decision maker and make best interest decisions on their behalf as described in the MCA code of Practice [see section 3.8].

1.7.3 Information Sharing
1.7.3.1 Information about an adult who may be at risk of abuse or neglect must be shared within the framework of the Safeguarding Adults information-sharing protocol [see section 3.11].

1.7.4 Professional Responsibilities
1.7.4.1 Some workers implementing these procedures may be ‘registered practitioners’ with a relevant body and/or have their work and conduct governed by them. The principal organisations are the:
   - General Social Care Council [gscc.org.uk]
   - Nursing and Midwifery Council [nmc-uk.org]
   - Health Professions Council [hpc-uk.org]
   - General Medical Council [gmc-uk.org]
   - General Optical Society [optical.org]
   - General Dental Society [gdc-uk.org]
   - Royal Pharmaceutical Society of Great Britain [rpsgb.org.uk].
Each of these:

- maintains a public register of qualified workers
- sets standards for conduct, performance and ethics
- considers allegations of misconduct, lack of competence or unfitness to practise and
- makes decisions as to whether a registered worker should remain on the register.

1.7.4.2 These procedures have been written to complement existing codes of conduct, organisational and legislative requirements placed on workers and volunteers. Any Safeguarding Adults work undertaken should therefore be commensurate with these.
SECTION 2 – PROCEDURES

2.1 Roles and Responsibilities of Organisations
2.1.1 This multi-agency procedure sets out what is expected of staff working within any organisation who have contact with Vulnerable Adults. All staff must work within the framework of the law and know what their responsibilities are under the procedure and to whom they should report. Organisations should have internal guidance for their own staff that complements this multi-agency procedure.

2.2 Best Practice in Safeguarding Adults work is to:

- recognise those individuals to whom the procedures apply
- take matters of potential abuse seriously and to discuss concerns with line managers
- actively listen to and record concerns without asking leading questions
- be timely, sensitive and maintain confidentiality as appropriate to each situation
- work in a co-ordinated way between organisations
- apply the service principles and practice of each organisation and this policy consistently
- promote human rights and every citizen’s access to the law
- support the rights of individuals by respecting self-determination and informed choice wherever possible
- acknowledge risk as an integral part of choice and decision-making
- act in ways which are proportionate to the perceived level of risk and seriousness
- ensure that risk assessments are completed and that these assessments are recorded and reviewed in order that risk can be minimised
- be effective in providing or negotiating solutions that are as simple and practical as possible and aim to prevent the risk of abuse recurring
- be sensitive to every individual’s identity including culture, beliefs and ethnic background, gender, disability, age and sexuality.

2.3 Definitions
2.3.1 Vulnerable Adult
2.3.1.1 Safeguarding Adults procedures relate to the multi-agency responses made to a person 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 is or may be unable to take care of him or herself, or able to protect him or herself against significant harm or exploitation’ [‘No Secrets’ DH 2000].

2.3.1.2 For purposes of ensuring consistent and widely understood terminology, these policy and procedures will use the phrase ‘Vulnerable Adults’ to identify those eligible for interventions within the procedures.
2.3.1.3 When a safeguarding concern is raised about an adult ‘who is or may be eligible for community care services’ the Fair Access to Care threshold for an investigation and support is met.

2.3.1.4 Safeguarding Adults [ADSS 2005] identifies a duty of care to all adults ‘whose independence and wellbeing is at risk due to abuse or neglect’. However, it may not always be appropriate to instigate these safeguarding procedures. Where a person is not vulnerable under the definition above, redirection to other services may be more appropriate, for example the criminal justice process and/or domestic violence services.

2.3.1.5 Safeguarding Adults [ADSS 2005] also identifies a duty of care to informal carers who have been assessed for support services in their own right.

2.3.2 Abuse

2.3.2.1 The currently used definition within Safeguarding Adults work remains that ‘Abuse is a violation of an individual’s human and civil rights by any other person or persons’ ['No Secrets' DH 2000].

2.3.2.2 Abuse is categorised into seven forms in ‘No Secrets’ and in this document: physical, sexual, financial, neglect, discriminatory, psychological and institutional (see sections 2.4, 3.3 & 3.4 for more details).

2.3.2.3 All forms of abuse have a negative emotional impact; the abused person may suffer feelings of insecurity, fear, rejection, hopelessness and loss of self-respect and self worth. Such damaging emotions inevitably affect the individual’s physical and mental health.

2.3.2.4 Abuse may consist of a single act or repeated acts, abuse may happen intentionally or unintentionally, and can take place in any relationship or setting.

2.3.2.5 Domestic Violence and Forced Marriage can also involve the abuse of a Vulnerable Adult.

Domestic Violence is ‘any violence between current and former partners in an intimate relationship, wherever the violence occurs’, and happens across society regardless of age, gender, race, sexuality, wealth and geography” [see section 3.14.2].

Forced Marriage is one in which one or both the spouses do not consent to the marriage and some element of duress is involved, including the use of physical and emotional pressure. Forced marriage is not sanctioned within any culture or religion [see sections 3.2.11 & 3.14.4].

2.3.2.6 Safeguarding Adults procedures must be instigated when the concern raised indicates significant harm or exploitation to the person subjected to it. No secrets refers to the definition:
‘harm should be taken to include not only ill-treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development’.  
[Law Commission 1995]

2.3.2.7 *Factors to be taken into consideration when assessing significant harm:*
- the impact on the individual – this should be determined by the vulnerable adult and the workers involved
- the individual’s wishes and feelings
- the impact [actual or potential] on other vulnerable adults or carers
- evidence of physical or emotional harm
- records of previous concerns or incidents
- independent corroborative information
- the views of other professionals involved
- it is important to remember that in some cases an accumulation of events as opposed to a single act may increase the severity of the concern

2.4 *Categories of abuse*

2.4.1 For the purposes of Safeguarding Adults work, data recording and monitoring, abuse is categorised under the following headings, although it must be noted that more than one can happen at the same time and that this list is not exhaustive:

2.4.2 *Physical:* includes hitting, slapping, pushing, kicking, the misuse of medication, restraint, or inappropriate sanctions.

2.4.3 *Psychological:* including emotional abuse, threats of harm or abandonment, forced marriage, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

2.4.4 *Sexual:* including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting.

2.4.5 *Financial or Material:* including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property.

2.4.6 *Neglect or acts of omission:* including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
2.4.7 *Discriminatory*: including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

2.4.8 *Institutional abuse*: can be different from other forms because it is about who abuses and how that abuse comes about. Institutional abuse can take any of the other forms.

2.4.9 Further details about the nature of abuse and how it may be indicated can be found in sections 3.3 to 3.6.

2.5 **Procedural Stages**

2.5.1 The following charts and flowchart give an overview of the Safeguarding Adults process, and are followed by more detailed information about procedural stages.

2.5.2 Professional judgement exercised within organisational policies and mutual cooperation will be key to operating the multi-agency Safeguarding Adults procedures. At each stage, decisions must be made about the most appropriate organisations and people to take the lead role in the safeguarding process. These decisions should follow multi agency discussions and be recorded and shared with the Adult Protection office.
Safeguarding Adults - Page 13

Safeguarding Adults Procedures Flowchart

Alert

Suspected Abuse of a Vulnerable Adult

Ensure immediate safety

Within organisations: report to designated person

Other referrals may be made directly

Referral

Initial information gathering, and consideration of capacity and consent

Referral made to relevant Safeguarding Manager within 24 hours

Safeguarding Assessment

Safeguarding Manager co-ordinates a Strategy Meeting or Discussion to plan responses and any investigations

Multi-Agency Investigation; gathering information from criminal, disciplinary, contractual and/or inspection sources

Safeguarding Plan & Review

Case Conference decides whether abuse took place, and identifies ongoing risks

A Safeguarding Plan is agreed in response to need or risk, and reviewed appropriately
<table>
<thead>
<tr>
<th>Stage of procedure</th>
<th>Role</th>
<th>Responsibility</th>
<th>Maximum time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alert</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting and recording any allegation or concerns about potential abuse or neglect and addressing any immediate protection issues</td>
<td>Everyone</td>
<td>Immediate action to safeguard; concerns to be reported on the same day</td>
<td></td>
</tr>
<tr>
<td><strong>Referral</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referring safeguarding concerns on to the safeguarding manager or to a referral agency [police or ‘councils with social services responsibilities’]</td>
<td>Designated staff within organisations</td>
<td>Within the same working day</td>
<td></td>
</tr>
<tr>
<td><strong>Safeguarding Assessment</strong></td>
<td>A</td>
<td></td>
<td>By the end of the working day following the one on which the referral was made</td>
</tr>
<tr>
<td>decision to investigate</td>
<td>Deciding whether ‘Safeguarding Adults’ procedures are appropriate to address the concern, or where not identifying alternative responses</td>
<td>Safeguarding Managers</td>
<td></td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>strategy</td>
<td>Formulating a multi-agency plan for investigating, assessing risk and addressing any protection needs</td>
<td>Safeguarding Managers</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>investigation</td>
<td>Co-ordinating and collecting information about the safeguarding concern and the context in which it happened which may also include the use of criminal and/or disciplinary investigations</td>
<td>Relevant practitioners from Health, Social Care and the Police, with the involvement of others</td>
</tr>
<tr>
<td><strong>Plan</strong></td>
<td></td>
<td></td>
<td>On the same day as the safeguarding case conference</td>
</tr>
<tr>
<td>Analysis of the concern raised, the investigation and the context in which it happened is undertaken at a multi-agency Safeguarding Case Conference</td>
<td>Safeguarding Partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The safeguarding plan is developed at the Safeguarding Case Conference to address any ongoing risks to the vulnerable adult and identify a core group to monitor them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Review</strong></td>
<td></td>
<td></td>
<td>The first review must be held within three months of the initial safeguarding case conference; subsequent reviews must be held within six monthly intervals</td>
</tr>
<tr>
<td>At review case conferences the safeguarding plan is reviewed and adapted to meet the ongoing protection needs of the vulnerable adult until it is agreed on a multi-agency basis that there are no ongoing protection issues</td>
<td>Safeguarding Partners</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 2.6 Alert

#### 2.6.1 What do we mean by an alert?

It is telling someone that you are aware or suspect that abuse has taken place, or that it may in the future. Everyone who works with vulnerable adults has a duty to share their concerns, even if the vulnerable adult asks them not to. It is always good practice to inform vulnerable adults of this duty.

*Anyone* can be the alerters:

- the victim
- a paid or informal carer
- a volunteer
- a General Practitioner
- a member of the public
- police officer
- fire service staff
- council staff
- health service staff
- DWP staff

All alerts must be made immediately.

#### 2.6.2 What to do if you suspect abuse

##### 2.6.2.1 Ensure Safety

The first priority is to ensure the safety and protection of vulnerable adults. In making the person [and others potentially at risk] safe, it may be necessary to inform emergency services. If medical treatment is not immediately required, medical examinations should be arranged following discussions with the Safeguarding Manager.

##### 2.6.2.2 Preserve Evidence

Where there are suspicions that a crime may have taken place, the police should be contacted immediately and physical, forensic and other evidence should be preserved.

Preserving forensic evidence includes:

- disturbing a ‘scene’ as little as possible, sealing off areas if possible
- not removing victim’s clothing
- discouraging washing/bathing
- not handling items which may hold DNA evidence
- putting any bedding, clothing which has been removed, or any significant items given to you [weapons etc.] in a safe dry place.

Other evidence can be obtained, or preserved by:

- not interviewing the victim
- not interviewing any potential witnesses
- not alerting the alleged perpetrator
- making a note of your observations in relation to the condition and attitude of the people involved and any actions you have taken.
2.6.2.3  Report and Record

2.6.2.3.1 The organisation you work for should have an internal safeguarding protocol with specific guidance on where or whom you should alert about potential abuse. If you are unsure who to share information with, inform your line manager. If your line manager is not available, you will need immediately to contact another Safeguarding Manager or referral agency ['Council with social services responsibilities’ or the police].

2.6.2.3.2 If you suspect that the person you would normally pass any alerts to may be a perpetrator or involved in some way, you will need to seek advice immediately from another Safeguarding Manager, your local Adult Protection Office, out of hours service or the police.

2.6.2.3.4 Records of incidents and concerns should be written as soon as possible, with the date, your signature and designation made clear. If records are hand-written, the original should be kept for evidential purposes.

2.6.2.3.5 Workers should be aware that their records relating to any alert, referral or investigation could be used as evidence in a range of procedures: disciplinary, criminal or at a safeguarding case conference.

2.6.3 Good Practice for Alerters:

- when you become aware of abuse or neglect, you should make sure that emergency assistance, where required, is summoned and that your concerns are reported to the appropriate person within your own organisation immediately
- any information given directly by the adult concerned should be listened to and recorded carefully, using the person’s own words
- only clarify the bare facts of the reported abuse or grounds for suspicion, do not ask leading questions e.g. suggesting names of who may have perpetrated abuse if the person does not disclose it
- if a vulnerable adult makes an allegation to you asking that you keep it confidential, you should inform the person that you will respect their right to confidentiality as far as you are able to, but, that you are not able to keep the matter secret
- do not take any actions which might alert the alleged perpetrator
- record all factual evidence accurately and clearly in line with your organisation’s requirements and policies
- never prevent or dissuade another person from raising concerns, suspicions or presenting evidence
- don’t discuss the incident with anyone without agreeing this with your line manager
2.7 Referral

2.7.1 What do we mean by the referral?

When the alert is formally reported to:
- a Safeguarding Manager or
- the relevant ‘Council with social services responsibilities’ or
- the police.

Some organisations will have their own Safeguarding Managers, who will respond to referrals.

If this is not the case, or you are not clear then the referral should be made directly to the local ‘Council with Social Services Responsibilities’ [see section 4 for contact details]. Note that some local councils may have transferred these responsibilities to NHS trusts.

For any Safeguarding Adults concerns which may involve a Crime, contact should be made with South Yorkshire Police via 0114 220 2020. It should be made clear that the report is about a Safeguarding Adults issue, the needs of the victim should be made clear at this stage and an incident number should be requested [see section 3.13].

2.7.2 The Safeguarding Manager or referral agency will record relevant information from the referrer about the alleged incident and its context.

2.7.3 If the alleged victim is already receiving services via care/case management or Care Programme Approach routes, this should not preclude a Safeguarding Adults referral where concerns are raised or abuse is disclosed [see section 3.14.1].

2.7.4 Where a vulnerable adult is alleged to be a perpetrator of abuse, a referral should be made and a multi-agency meeting convened.

2.7.5 Where there is easily accessible information to confirm that the alleged abuse could have taken place, this should be gathered by the referrer and shared with the safeguarding manager, referral agency and/or the police if a crime is suspected. This could include checking staff rotas and incident reports, providing information about past incidents or concerns from internal records, and recording injuries on body charts. This is primarily a paper exercise and should not involve conducting interviews.

2.7.6 In accordance with National Reporting Requirements, the following information should be gathered and shared as a minimum:

**REFERRER INFORMATION**

*Person making referral:*
Name, Organisation, Address, Phone/email, Date and time of referral, signature

*Source of information/alert received from:*
Name, Organisation, Address, Phone/email, Date and time of alert
ALLEGED VICTIM
Name, Male/Female, Date of Birth, Receiving Community Services? [Give details if yes, if no please detail nature of disability/how eligibility requirements potentially met], Current Address, Home address [If person is in residential care please give previous home address], Legal Status, Ethnic Origin. Consent obtained for referral? If no, give reason.

ALLEGED ABUSE
Form/type of abuse
Location of alleged victim/Venue of alleged abuse
Were Drugs or Alcohol involved?
Was Domestic Violence a factor?

DETAILS OF SAFEGUARDING CONCERNS AND INITIAL RESPONSE
Include a Summary and attach/forward supporting documentation.
Is any Supporting Documentation supplied? [please list]

RISKS TO OTHERS e.g. children or other vulnerable adults

ALLEGATION MADE AGAINST
Name, Male/Female, Date of Birth, Address, Phone/email, Relationship to alleged victim, Is the person aware of referral?

2.7.7 Lack of access to the necessary information should not delay the referral.

2.7.8 All Safeguarding Adults referrals should be copied to the Adult Protection Office by the Safeguarding Manager.

2.7.9 Good Practice for Referrers:
• check that immediate safety has been considered - e.g. medical attention, emergency police contact
• consider suspending workers against whom allegations have been made
• assess the person’s mental capacity and ability to consent
• if consent has been obtained, record the person’s understanding of how the information will be shared and used
• the Commission for Social Care Inspection (CSCI) must be informed if staff are suspended by registered care providers and a referral must be made to POVA for a provisional listing (see information section pg 52)
• supply all information you can with regard to the alleged incident – this should be factual rather than opinion
• avoid investigative questioning at this stage
• share information about concerns within the framework of the Safeguarding Adults Information Sharing Protocol [see section 3.11]
• do not contact the alleged abuser until there is an agreed safeguarding assessment strategy - unless this is part of emergency action needed to safeguard the adult or others at risk which might include the suspension of staff or volunteers.
2.8 Safeguarding Assessments

2.8.1 What is a Safeguarding Assessment?
There are 3 stages, which are the responsibility of Safeguarding Managers:

A – Decision to investigate – i.e. whether the referral meets the criteria for a Safeguarding Adults investigation, or identifying other appropriate responses

B - Developing a safeguarding strategy – reaching agreements on how any investigation is to be carried out via a multi-agency meeting or discussion

C - Investigation – the collection of the information about abuse or neglect that has happened or might happen which may also include co-ordination of the use of criminal or disciplinary investigations alongside Safeguarding Adults processes

2.9 A – Decision to Investigate

2.9.1 The Safeguarding Manager must decide whether Safeguarding Adults procedures are appropriate to address the concerns referred or identify alternative responses. The Safeguarding Manager should record the decision in accordance with this policy and procedures and within their organisation's recording policy. A copy must be sent to the Adult Protection Office.

2.9.2 A decision about whether the referral meets the threshold for an investigation must be made on the same day and allocated to a worker to investigate, within 24 hours. Decisions to investigate should be guided by the definitions of vulnerable adult, abuse and significant harm in section 2.3. All concerns that meet the threshold for investigation should be discussed with the police unless it is clear that no crime has been committed.

2.9.3 Where the adult is not covered by this policy, information should be given, or a referral made to an appropriate service. This action should be recorded.

2.9.4 If thresholds are met but the vulnerable adult refuses or objects to taking part in the process, this information should form part of the strategy meeting/discussion but should not be used as a reason not to proceed [see flowchart at 2.9.8].

2.9.5 If it is the view of professionals that the best interests of a vulnerable adult is not being served by decisions made about their needs or situation by family or carers, and that this could result in significant harm, then Safeguarding Adults procedures should be invoked.

2.9.6 The reasons for any decisions made not to progress to investigation must be recorded by the Safeguarding Manager and copied to the Adult Protection Office.

2.9.7 Urgent action needed, which has not already been taken at the Alert or referral stages (such as immediate medical attention, police involvement or removal of the vulnerable adult in order to ensure their safety), should be undertaken.
2.9.9 The Safeguarding Manager or referral agency receiving the initial referral will ensure that other relevant agencies are notified according to the following principles:
- the Adult Protection Office will receive notification of all referrals
- the Police should be notified of all referrals unless it is clear that no crime has been committed
- the relevant Health Service Safeguarding Manager will be notified of referrals involving Health Service premises, staff or patients
- the CSCI will be informed of alerts from registered services
- contracts units/sections should be informed of allegations relating to care settings where consideration may need to be given to suspension of placements.
2.9.10 Children
2.9.10.1 Where the referral indicates that children may be at risk, the Safeguarding Manager will contact Safeguarding Children’s services. Where appropriate, child and adult safety services may need to work collaboratively in order to protect all involved.

2.9.10.2 If a child [under 18] is alleged to have perpetrated abuse against a vulnerable adult, contact should be made with the local referral point for children’s services in order to ensure that the needs of the child are considered alongside those of the vulnerable adult.

2.9.11 ‘Out of Area’ Arrangements and ‘Cross Border’ Issues

2.9.11.1 The increased risk to vulnerable adults whose care arrangements are complicated by cross boundary considerations must be recognised. The authority where the abuse happened [the ‘host authority’] should always take the initial lead on responding to the referral. This may include taking immediate action to protect the adult, if appropriate, and arranging an early discussion with the police if a criminal offence may have been committed.

2.9.11.2 The host authority will also co-ordinate initial information gathering, background checks and ensure a prompt notification to the ‘placing authority’ and other relevant agencies.

2.9.11.3 Where care arrangements exist across boundaries, it is the responsibility of the host authority to co-ordinate any investigation. If the alleged abuse takes place in a residential or nursing home, other people could potentially be at risk and enquiries should be carried out with this in mind.

2.9.11.4 The placing authority will be responsible for providing support to the vulnerable adult and planning their future care needs, either as an alleged victim or alleged perpetrator. The placing authority should nominate a link person for liaison purposes during the investigation. They will be invited to attend any Safeguarding Adults Strategy meeting and/or may be required to submit a written report.

2.9.12 Good Practice for Safeguarding Managers in deciding to investigate:

- consider definitions [vulnerable adult, significant harm etc.]
- clarify referral information, ideally by a discussion with the referrer
- where the adult is not covered by this policy, information should be given, or a referral made to an appropriate service, and this action should be recorded
- check previous records re. the alleged victim and perpetrator
- consider risks to the alleged victim or other vulnerable adults or carers
- consider whether a crime has been potentially committed and consult with the police as they may hold pertinent information
- consider whether capacity and consent issues have been considered within the referral process [ see section 3.8]
- remember that an accumulation of events [as opposed to a single act] may increase the severity of the concern.
2.10 B – Safeguarding Strategy

2.10.1 What is a Safeguarding Assessment Strategy?

The strategy can be developed using formal meetings or through discussions, and is the responsibility of the Safeguarding Manager.

The purpose of the Safeguarding Assessment Strategy is to plan a multi agency investigation i.e.:

- Which process/es are to be used to investigate?
- In what order are investigative processes to be undertaken?
- How is the investigation to be conducted [roles and responsibilities]?
- How and when is the investigation team going to provide feedback?

2.10.2 A strategy meeting or discussion should be held within ten working days of the decision to investigate. All relevant professionals and organisations should be included in strategies, inclusion to be the decision of the safeguarding manager. A standard agenda will be used [see page 68].

2.10.3 Where a service provider is not involved in the strategy meeting/discussion, they must be informed as soon as possible, how and by whom the investigation is to be conducted.

2.10.4 Any disagreements arising during the safeguarding strategy e.g. around the appropriateness of organisations/workers' involvement should be referred to the Safeguarding Adults Co-ordinator.

2.10.5 Timescales for the investigation and Safeguarding Case Conferences are to form part of the strategy meeting or discussion.

2.10.6 Strategy development is the responsibility of all the professionals involved; it is not appropriate for victims to attend meetings or be part of discussions at this stage. However, their wishes and views must be represented and taken into account. The strategy should include how capacity and consent issues are to be addressed.

2.10.7 As part of the strategy there will be active consideration, in consultation with the police and legal services, of the potential use of relevant legislation. The police will make a decision as to whether an Achieving Best Evidence interview is necessary; this should be carried out as soon as possible and within ten days of the strategy meeting.

2.10.8 In some cases the alleged perpetrator may themselves be a vulnerable adult. Their needs must be given consideration, for instance they may require additional support, advocacy or help with communication. Where the alleged perpetrator is an informal carer, they may require a carer’s assessment.

2.10.9 Medical examination/treatment (other than in emergency) should not be given if sexual assault is suspected. The police will arrange for a Police Surgeon to conduct an examination in order to gather evidence.
2.10.10 Where domestic violence is a feature of a referral, domestic violence support services should be involved in developing the strategy [see sections 3.14.2 and 4].

2.10.11 Decisions and reasons not to proceed with the investigation, to take no further action, or to use other responses, must be recorded in the minutes.

2.10.12 Situations where agreement can not be reached about the strategy to be followed should be referred to the Safeguarding Adults Coordinator.

2.10.13 Good Practice in Safeguarding Assessment Strategies:

- it may be more effective to formulate the initial strategy through a series of telephone conversations, e-mails, or through a virtual meeting
- investigations should be led by the most appropriate agency
- the order in which investigative processes are to be undertaken should be agreed by all parties
- where criminal offences are suspected, the police will lead the investigation which must have primacy over other enquiries
- Health Service Managers (if designated as Safeguarding Managers) may co-ordinate the investigative process where incidents happen in health care settings
- regulatory bodies such as the CSCI or Healthcare Commission should be notified of incidents and where appropriate involved in the strategy process
- records of all decisions made, whether in formal meetings or through discussions/emails etc. should be shared with relevant professionals and the Adult Protection Office on form 3 [page 67]

2.11 C – Investigation

2.11.1 What is the investigation?

Co-ordinating and collecting information about the safeguarding concern and the context in which it happened in order to inform Safeguarding Case Conference decisions. This may also involve the use of criminal or disciplinary investigations.

2.11.2 Safeguarding Managers are responsible for monitoring and co-ordinating investigations, with workers from a range of organisations involved in investigative processes.

2.11.3 Each organisation will make comprehensive records of its work and the findings of any safeguarding assessment investigation activity it carries out. Workers must follow this policy and their own organisation’s recording policy.

2.11.4 Each organisation will carry out the actions it agreed in the strategy discussion, and report back to the Safeguarding Manager any changes that need to be made to that plan.
2.11.5 The CSCI and/or Healthcare Commission should always be included in investigations involving regulated care providers and enquiries should make reference to national guidance regarding arrangements for the protection of vulnerable adults.

2.11.6 Evidence should be collected and preserved, with relevant files and documents secured, using the appropriate powers of partner organisations where necessary.

2.11.7 All organisations must provide investigators with access to all records e.g. incident reports, daily logs, interviews with staff, disciplinary records etc. in accordance with the Safeguarding Adults Information Sharing Protocol.

2.11.8 Where a staff member is the alleged perpetrator, the employing organisation will be responsible for undertaking the disciplinary investigation, appointing an objective and if necessary independent investigator, e.g. another manager from within the organisation, who will liaise with the Safeguarding Manager.

2.11.9 Disciplinary investigations must be planned in co-ordination with the Safeguarding Adults investigation.

2.11.10 If during the investigation additional victims and/or perpetrators are identified, or for other reasons the safeguarding strategy needs to be significantly amended, then a further Safeguarding Strategy Meeting can be convened to redirect the investigation.

2.11.11 If it is decided that the outcome of an investigation is not going to be fed back to a Safeguarding Adults Case Conference, then the Safeguarding Adults Co-ordinator should be informed at the time that decision is made.

2.11.12 Investigations should be based on the principles of:

A - **Involving and informing alleged victims:**
- Alleged victims should be informed of progress, even when they are unwilling to take an active part in the process.
- The communication needs, wishes and decision-making capacity of alleged victims should be properly assessed, and consideration given to the use of victim support or independent advocacy; an interpreter or intermediary may also be required.

B – **Involving alleged perpetrators:**
- Opportunities must always be given to allow the views of the perpetrator to be included within the investigation, Safeguarding Assessments and Safeguarding Case Conferences, unless to do so would threaten the safety of the alleged victim. The reason for such a decision must be recorded.
- Where a staff member or volunteer is the alleged perpetrator, their employing organisation must ensure that they are given the appropriate support and that their views are represented to the case conference.
- Where the alleged perpetrator is subject to legal proceedings, then their representative should be informed/involved.

C - **Gathering information:** from all agencies about the incident and its context
- Where the adult who may be at risk has mental capacity, they should usually be the first person to be interviewed as part of the safeguarding assessment investigation.
- Interviews should be undertaken by someone who has had specific investigator training. If a non-trained person is felt to be the most appropriate for reasons of relationship or communication, they should be supported by a trained person.
• All relevant information from records within organisations should be collated; this may be about current concerns relating to abuse or neglect, past records, inspection reports, contracting concerns etc.

**D – Comprehensive Risk Assessment**

Workers should follow organisational policies and share the results in accordance with the Safeguarding Adults Information Sharing Protocol.

Risk assessment should:
• assess current, past and future risk to the alleged victim and other vulnerable adults, and workers
• identify risks: to whom and from what
• involve all relevant professionals and individuals in the assessment of risk and risk management plans.

2.11.13 Where there is insufficient evidence to support a criminal prosecution, other steps may still be required to protect the vulnerable adult. Disciplinary action may still be appropriate. The Safeguarding Adults investigation should still be completed, culminating in a Safeguarding Case Conference.

2.11.14 The findings of the investigation should be shared with the vulnerable adult and the alleged perpetrator at least 5 days prior to the case conference either verbally, or where possible by sharing the case conference report, unless to do so would threaten the safety of the alleged victim. The reason for such a decision must be recorded.

2.11.15 **Good practice in Investigating:**

<table>
<thead>
<tr>
<th>Checklist for Assessing Risk</th>
</tr>
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<tbody>
<tr>
<td>• What risks have been identified? (To the individual, other vulnerable adults, carers, others.)</td>
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<tr>
<td>• How was the risk identified and by whom?</td>
</tr>
<tr>
<td>• What supporting evidence is there?</td>
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<tr>
<td>• past events or concerns relating to the alleged victim or perpetrator e.g. complaints, disciplinary action, convictions including cautions and any other criminal intelligence</td>
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<tr>
<td>• observations</td>
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<tr>
<td>• physical evidence</td>
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<td>• professional reports.</td>
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<tr>
<td>• Is an assessment of capacity required?</td>
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<tr>
<td>• What are the wishes of the individual involved in relation to the process used to investigate, and to the outcome?</td>
</tr>
<tr>
<td>• What standards and measures are currently in place to reduce the risk?</td>
</tr>
<tr>
<td>• What are the predisposing factors or triggers?</td>
</tr>
<tr>
<td>• What actions can be taken to diminish the risk?</td>
</tr>
</tbody>
</table>
2.12 Safeguarding Case Conferences and Plans

2.12.1 What is a Safeguarding Case Conference?

An independently chaired, multi-agency meeting to:
- consider the outcome of the investigation
- arrive at decisions about whether abuse took place
- assess ongoing risk factors and
- produce a safeguarding plan when appropriate.

2.12.2 What is a safeguarding plan?

A multi-agency plan, which addresses ongoing risk factors and includes allocation of tasks, realistic timescales to reduce or remove risk and review dates.

2.12.3 It is the responsibility of the Safeguarding Manager to oversee the Safeguarding Adults process and ensure that it culminates in an independently chaired Safeguarding Case Conference. All safeguarding investigations must culminate in a Safeguarding Case Conference. The only exceptions to this are when:
- the investigation concludes that the allegation was malicious and unfounded
- the investigation concludes that the alleged abuse could not possibly have taken place.

2.12.4 Whilst carrying out the role and duties of Safeguarding Managers, people are acting on behalf of the local Safeguarding Adults’ Partnership and are accountable to it via their organisation and the Safeguarding Adults Board.

2.12.5 The outcomes of the Safeguarding Case Conference should be to:
- state whether on a balance of probabilities abuse has been substantiated or not
- identify the category or categories in which the abuse has taken place
- decide if there is ongoing risk and, if so, devise a safeguarding plan, identifying actions, roles and timescales
- agree membership of core group
- set a date to review the safeguarding plan
- make recommendations to care plans where ongoing risk is not identified
- identify how people unable to attend the conference are informed of the outcomes.

2.12.6 Those attending conferences should be there because they have a significant contribution to make, arising from professional expertise, knowledge of the vulnerable adult involved, or of the services available.

2.12.7 Each organisation that had a role in the investigation/assessment will submit a written report to the Case Conference Chair in advance of the conference, in line with local agreements. In some cases the police may consider that a written report may prejudice a criminal case and will therefore give verbal feedback.
2.12.8 If an organisation has not been part of a Safeguarding Adults investigation, due to decisions made in the safeguarding strategy, the findings of the investigation should be shared at least 5 days before the case conference in order for any internal enquiries to be made, and a response prepared.

2.12.9 Reports of safeguarding assessment investigations should be shared with the vulnerable adult/s concerned prior to the meeting, at least 5 days before the case conference, with the involvement of a family member or advocate if appropriate.

2.12.10 Wherever possible, the vulnerable adult should attend the Safeguarding Case Conference and be included in developing the safeguarding plan. If this is not possible, the reason should be recorded at the conference and their views represented in a format agreed with them beforehand.

2.12.11 Where an adult does not have the mental capacity to be included, a person acting in their best interests should be nominated to take part in the Safeguarding Case Conference risk assessment and safeguarding plan. Consideration should be given to the involvement of an Independent Mental Capacity Advocate, should the criteria be met [see appendix 6].

2.12.12 Wherever possible the alleged perpetrator should be invited to the Safeguarding Case Conference. If this is not possible their views must be represented. The investigating professional, in consultation with the Safeguarding Manager, will decide if the alleged perpetrator should attend the conference.

2.12.13 The reason for all exclusions must be recorded and communicated to the alleged perpetrator and the conference, unless to do so would threaten the safety of the alleged victim. The reason for such a decision must be recorded. Grounds for exclusion may include:

- the alleged victim’s wish to attend must always override the wishes of the alleged perpetrator
- a history of violence or threats that may endanger any conference member.

2.12.14 Some members of the conference may also need to be excluded during parts of the conference where details of the alleged victim’s disclosure and/or evidence, which form part of an ongoing criminal investigation, are shared; or when details of relevant criminal histories or sensitive medical histories are shared.

2.12.15 Each organisation that had a role in the investigation/assessment will present their written report to the Safeguarding Case Conference. Reports should be free from jargon and be available in a format that the vulnerable adult can understand [see report format at section 3.12, form 8].

2.12.16 There should be sufficient information and expertise available, through personal representation and written reports, to enable the conference to make an informed decision about what action is needed to safeguard the vulnerable adult involved, and to make realistic and workable proposals for taking that action forward.
2.12.17 The arrangements for monitoring individual cases will be specified in the Safeguarding Plan [see section 3.12, form 12].

2.12.18 Following the Safeguarding Case Conference, and where appropriate, feedback should be given to those who initially reported the abuse or neglect.

2.12.19 Good practice in Safeguarding Case Conferences:

- When convening a Safeguarding Case Conference, agree a convenient time and date, giving reasonable consideration to people’s wishes e.g. accessible venue, time of day to suit health needs or caring responsibilities.
- A conference which is larger than it needs to be can inhibit discussion and intimidate vulnerable adults and families.
- The alleged victim and perpetrator’s views should be heard wherever possible.
- The chair’s role is to raise issues, ask questions and give procedural guidance which will facilitate a consensus being reached.
- A safeguarding conference does not use the same burden of proof as a criminal court ‘beyond reasonable doubt’. Decisions will be based on the balance of probability.
- Minutes of the meeting will be circulated to all attendees, and others as agreed by the chair.
- Safeguarding Plans should:
  - take account of the wishes of the individual
  - relate to a specific time-scale and setting
  - detail arrangements for monitoring and review
  - identify factors that might increase the identified risk and agree contingency plans in such circumstances.

2.13 Safeguarding Plan Reviews

2.13.1 The purpose of the meeting is to review the Safeguarding Plan. Where there is no longer a need for a Safeguarding Plan, the case exits Safeguarding Adults Procedures. There may, however, be a need for ongoing casework. This decision should be considered by those present at the last review case conference and anyone else currently working with the victim.

2.13.2 An adult with mental capacity should, wherever possible, be included in the review. Those lacking capacity should have representation.

2.13.3 The initial review should be held within three months and subsequent reviews at no longer than six monthly intervals.

2.13.4 The implementation of the safeguarding plan should be monitored, between review case conferences, by a Core Group of key individuals identified at the Safeguarding Case Conference.
2.14 Serious Case Reviews

2.14.1 The Safeguarding Adults Boards in South Yorkshire have the lead responsibility for conducting serious case reviews, using the guidance contained in appendix 5.

2.14.2 A serious case review must be considered when:

A. A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death. In such circumstances there should be a review into the involvement of agencies and professionals associated with the vulnerable adult.

B. A vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults.

C. Serious abuse takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case.
3.1 The legal and policy context of Safeguarding Adults work

3.1.1 This section provides an overview of the framework within which Safeguarding Adults work is placed. It is intended to be a signpost to further reading, advice and the application of legislation and policy.

3.1.2 The legislative issues relating to the protection and safeguarding of vulnerable adults can be complex and confusing. The law is constantly changing. If workers are unclear about its application, they should seek advice from their managers or legal departments.

3.1.3 Guidance and Standards
The key guidance for these policy and procedures are:

*No Secrets [DH 2000]*
The first national policy developed for the protection of vulnerable adults, for use by all health and social care organisations and the police. It introduced guidance around local multi-agency arrangements and was issued under Section 7 of the Local Authority Social Services Act 1970. Its implementation is led by local authorities with social services responsibilities.

*Safeguarding Adults [ADSS 2005]*
This document builds on ‘No Secrets’ and collects best practice and aspirations together into a set of good practice standards – which is intended to be used as an audit tool and guide by all those implementing Safeguarding Adults work.

3.1.4 Relevant legal statutes

*Abuse that is a crime*
- Crime and Disorder Act 1998
- Criminal Justice Act 1967
- Domestic Violence Crime and Victims Act 2004
- Family Law Act 1996
- Fraud Act 2006
- Medicines Act 1969
- Offences Against the Person Act 1861
- Police and Criminal Evidence Act 1970
- Protection from Harassment Act 1997
- Public Order Act 1986
- Sexual Offences Act 1956
- Sexual Offences Act 1967
- Sexual Offences Act 2003
- Theft Acts 1968 and 1978
- Youth Justice and Criminal Evidence Act 1999
Provision of health and social care services

- Carers (Recognition and Services) Act 1995
- Carers and Disabled Children Act (2000)
- Care Standards Act 2000
- Chronically Sick and Disabled Persons Act 1970
- Community Care (Direct Payments) Act 1996
- Disabled Persons (Service Consultation and Representation) Act 1986
- Employments Rights Act 1996
- Health and Social Care Act 2001
- Health Service and Public Health Act 1968
- Health Act 1999
- Housing Act 1985
- Housing Act 1996
- Housing Act 2004
- Local Authority Social Services Act 1970
- Mental Capacity Act 2005
- Mental Health Act 1983
- National Assistance Act 1948
- National Assistance (Amendment) Act 1951
- National Health Service Act 1977
- National Health Service and Community Care Act 1990
- Public Health Act 1936 and Public Health Act 1961
- Registered Homes (Amendment) Act 1991

Other relevant statutes & statutory instruments

- Court of Protection Rules 1994
- Data Protection Act 1998
- Disability Discrimination Acts 1995 & 2005
- Enduring Power of Attorney Act 1985
- Health & Safety at Work Act, 1974
- Human Rights Act 1998
- Mental Capacity Act 2005
- Power of Attorney Act 1971
- Public Interest Disclosure Act 1998
- Race Relations (Amendment) Act 2000
- Safeguarding Vulnerable Groups Act 2006
- Social Security (Claims and Payments) Regulations 1987
3.2 Potential Legal responses to abuse

There are a number of statutory powers available, some of which are referred to below. Where there are potential criminal activities that require police investigation, they will obtain evidence from the victim and witnesses. In criminal proceedings the evidence must establish the case 'beyond reasonable doubt'. In civil cases the burden of proof is ‘on the balance of probabilities’.

3.2.1 Physical Abuse

Homicide

Two general homicide offences, murder and manslaughter, cover the ways in which someone might be at fault in killing [see also familial homicide in section 3.2.8].

**Murder** is committed when someone [D] unlawfully kills another person [V] with an intention either to kill V or to do V serious harm.

**Manslaughter** can be committed in one of four ways:

1. killing by conduct that D knew involved a risk of killing or causing serious harm ['reckless manslaughter']
2. killing by conduct that was grossly negligent given the risk of killing ['gross negligence manslaughter']
3. killing by conduct taking the form of an unlawful act involving a danger of some harm to the person ['unlawful act manslaughter'] or
4. killing with the intent for murder but where a partial defence applies, namely provocation, diminished responsibility or killing pursuant to a suicide pact.

The term ‘involuntary manslaughter’ is commonly used to describe a manslaughter falling within 1 to 3, while 4 is referred to as ‘voluntary manslaughter’.

**Common assault** – a person is guilty of an assault if she/he intentionally or recklessly causes another person to apprehend the application of immediate, unlawful force to the body of another person – even if there is no physical injury. In relation to Safeguarding Adults, any act indicating an immediate threat of violence constitutes an assault.

**Offences against the Person Act** 1861 section 47 deals with the offence of an assault which leaves physical injury and sections 18 and 20 deal with wounding with intent to do grievous bodily harm where the physical injury is more serious.

**Battery** is the intentional or reckless infliction of unlawful force or personal violence.

**Restraint** or threatened restraint can amount to assault or battery, as can any practice involving physical compulsion such as force feeding of food or medication. The detention of a person against their will can constitute the civil wrong of false imprisonment and such actions may also contravene The Human Rights Act 1998.

**Public Order Act** (1986) sections (3 & 4) Affray or Fear or provocation of violence. This Act creates a number of offences involving the use of or threat of violence, or the use of threatening, abusive or insulting words or behaviour or disorderly behaviour intending to and causing harassment, alarm or distress. Some of the potential offences are not committed if the events take place in a dwelling house.
Protection from Harassment Act 1997 makes it a criminal offence to pursue a course of conduct, which amounts to harassment of a person. It is also an Offence to engage in conduct that puts a person in fear that violence will be used against him or her. A course of conduct means that there must be two or more incidents representing harassment and the person who is carrying out the harassment must know or ought to know that the conduct would amount to harassment. Under section 5 of the Act the Court can make a restraining order on conviction in order to protect the victim.

Improper Medication – Medication Act 1968
It is an offence to administer drugs that have been prescribed to someone else.

3.2.2 Sexual Abuse
The Sexual Offences Act 2003 clarified the offences of:
Rape
Rape is now classified as penetration by the penis of somebody’s vagina, anus or mouth, without their consent. Rape can be committed against men or women, but since it involves penile penetration it is only committed by men.

Assault by penetration
Under this new law, it is an offence to penetrate the anus or vagina of someone else with any part of the body or with an object, if the penetration is sexual and if the person does not consent.

Sexual assault
This law covers any kind of intentional sexual touching of somebody else without their consent. It includes touching any part of their body, clothed or unclothed, either with your body or with an object.

Causing a person to engage in sexual activity without consent
Because consent is central to this area of law, the Sexual Offences Act sets down, for the first time, a clear definition and new responsibilities surrounding consent.

‘A person consents if s/he agrees by choice and has the freedom and capacity to make that choice.’

Now, if a defendant in court wants to claim they believed the other person was consenting, they will have to show they have reasonable grounds for that belief. Giving consent is active, not passive. It means freely choosing to say ‘yes’. It is up to everyone to make sure that their partner agrees to sexual activity.

Additional offences introduced by the act are:
• Abuse of position of trust - designed to protect young people who are potentially vulnerable to sexual abuse from people in positions of trust in places, including hospitals, clinics, care homes, community home, nursing homes etc.
• Offences against persons with mental disorder. Sections 30 – 33 relate to offences against people who cannot legally consent to sexual activity because of a mental disorder impeding choice. Sections 34 – 37 relate to offences against people who may or may not be able to consent to sexual activity but who are vulnerable to inducements, threats or deceptions because of a mental disorder.
Mental Health Act 1959

Sexual intercourse with patients/residents It is an offence for a man employed in or managing a hospital or a mental nursing home to have unlawful sexual intercourse with a woman who is receiving treatment in that hospital or home or on an outpatient basis.

It is also an offence to have unlawful sexual intercourse with a woman who is subject to a guardianship order under the MHA 1983 or otherwise in his custody or care or under part III of the National Assistance Act 1948 or the National Health Service Act 1977 or a resident within the meaning of the Care Standards Act.

These offences also apply to acts of buggery or gross indecency with male patients or residents. No offence is committed if the man did not know and had no reason to believe that the patient or resident was suffering from mental disorder.

3.2.3 Financial Abuse.

Theft Act 1968

Section 1 defines theft as the dishonest appropriation of property belonging to another with the intention of permanently depriving the owner of it.

Burglary (Section 9 - Theft Act (TA) 1968) is the entry as a trespasser to a building with the intention of stealing, inflicting GBH or unlawful damage therein.

Robbery is theft aggravated by the use of or threat of force (S8 of same act).

Blackmail (S21 TA 1968) – someone is guilty of blackmail if with a view to gain for him/herself or another or with intent to cause loss to another, he/she makes any unwarranted demand with menaces. For the purpose of this offence, a demand with menaces is unwarranted unless the person making it does so in the belief that he/she has reasonable grounds for making the demand, and that the use of the menaces is a proper means of reinforcing the demand.

The Fraud Act 2006

Sections 1 – 3 of the Act establish a new general offence of fraud, which can be committed in three ways: fraud by false representation; fraud by failing to disclose information; and fraud by abuse of position. The behaviour must be dishonest and aimed at making a gain or causing a loss. Section 4 makes it an offence to commit fraud by abuse of position; meaning taking advantage of a position where one person is expected to safeguard another’s financial interests. Section 4 would cover, for example, a case where a person is employed to care for an elderly or disabled person has access to that person’s bank account and abuses his position by transferring funds to invest in a high-risk business venture of his own.

Councils with Social Services Responsibilities have a duty to provide temporary protection for movable property of people in hospital or residential/nursing care. (National Assistance Act 1948 S48). It applies when there appears to be a danger of loss or damage to the patients/residents movable property by reason that the person is not able to protect his or her own belongings.
3.2.4 Neglect and Omission.
Mental Capacity Act 2005 Section 44 introduces a new offence. If a person has the care of someone who lacks, or whom they reasonably believe to lack capacity, [including the donee of a lasting power of attorney, or an enduring power of attorney]; then they are guilty of an offence if they ill-treat or ‘wilfully neglect’ them. How the law will be interpreted is open to case law.

Under the Law of Tort a duty of care is imposed on carers. The carer must perform to a reasonable standard those tasks, which they undertake. Serious deficiencies may constitute negligence. This would have to be dealt with in a civil court.

A person with mental capacity is entitled to refuse the provision of services even though the professional opinion is that this will cause deterioration or abuse or neglect. There is provision for intervention where the Mental Capacity Act and the Mental Health Act are not relevant under the National Assistance Act 1948 section 47. However, any action under this provision should only be taken after consideration of the Article 5 HRA 1998 which provides for liberty and security to ensure that any action is compliant and detention is not unlawful.

National Assistance Act 1948
Removal to suitable premises of persons in need of care and attention Section 47

gives power to the relevant district council via the community physician to apply to a magistrates court to remove a person from his/her home in order to secure the care and attention they need on the grounds:

• That the person is suffering from grave, chronic disease or, being aged and infirm or physically incapacitated, if living in unsanitary conditions; and
• That the person in unable to care for him/herself and is not receiving, proper care and attention from other persons and
• That in the opinion of a community physician his/her removal is necessary in the interests of preventing injury to the health of, or serious nuisance to other persons. This must be supported by a certificate from the community physician – in practice it is rarely used but could be used for serious cases of self neglect or neglect. Normally 7 days notice is required but under section 1 of the National Assistance (Amendment ) Act 1951 it can be done immediately and without notice if it is an emergency. Removal is normally to a residential or hospital placement. Legal advice should be sought before making any applications.

In addition to this the council may obtain a warrant to enter and cleanse the property if it constitutes a public health risk (S287 Public Health Act 1936).

Mental Health Act 1983

The Act provides for detention and treatment of persons with a mental disorder within the definition of the Act. If use is being considered an approved social worker should advise.
Mental Health Act 1983 section 115
Powers of Entry and Inspection allows an Approved Social Worker (ASW) to enter a property if an adult is mentally disordered or that there is reasonable cause to believe that the patient is not under proper care. Forcible entry is not permitted but obstruction of an inspection is an offence under S129. If a criminal offence is suspected and there is a matter of risk to life or limb, the police can access the property under the Police and Criminal Evidence Act 1984.

Mental Health Act 1983 section 135
Warrant to search for and remove patients. An application can be made to the Magistrates Court for a warrant to the police for permission to gain entry forcibly, if necessary to remove a person suffering from mental disorder to a place of safety. An order under this section will be made if an approved social worker has grounds to believe that
• the person has been/is being ill treated, neglected, or kept in otherwise than under proper control, in any place within the court’s jurisdiction; or
• the person is living alone in any such place and is unable to care for him/herself and is living alone in any such place. The period of detention cannot exceed 72 hours.

Mental Health Act 1983 section 7
Guardianship
A person over 16 may be received into the guardianship of a local authority or of a person approved by the authority if they meet the MHA 1983 criteria and guardianship is necessary for the welfare of the patient or for the protection of other persons. There are specific procedures for application for guardianship and discharge under the Act, which must be followed. Guardianship runs for an initial period of 6 months, which can be renewed for a further period of 6 months and thereafter for yearly periods. It confers on the guardian three particular powers –
• to require the patient to reside at a specified place;
• to require the patient to attend at specified places and times for the purpose of medical treatment, occupation, education or training;
• to require access to the patient to be given at any place where he or she is residing for certain specified persons.

This may be of help where a third party is preventing access to a vulnerable adult.

Guardianship does not give a power to detain a patient physically or compel a person to have medical treatment, although there is a power to take a patient into custody and return him/her to the place s/he is required to live if s/he absents themselves without the guardian’s consent.

Mental Health Act 1983 section 136
Mentally disordered persons found in public places
If a police officer finds a person who appears to be suffering from mental disorder and to be in immediate need of care and control in a public place, they can be removed to a place of safety as in s135. A person moved under this section can be detained for up to 72 hours to enable them to be examined by a doctor and interviewed by an ASW and any necessary arrangements made for his or her treatment or care.
3.2.5 Discriminatory Abuse

Racial Discrimination (Race Relations Act 1976)
It is unlawful for a person to discriminate against another on racial grounds including employment, education facilities, services and premises.

Sexual Discrimination (Sex Discrimination Act 1975)
Makes it unlawful for a person to discriminate again a man or woman on the grounds of his/her sex, in the same areas as above.

Disability Discrimination (Disability Discrimination Act 1995)
Makes it unlawful to discriminate against a person with a disability in the same areas as above. It requires employers to make reasonable adjustments or arrangements to avoid placing a disabled person at a substantial disadvantage in comparison to non-disabled people.

The Equality Act 2006
Makes discrimination unlawful on the grounds of religion or belief in the provision of goods, facilities and services, the disposal and management of premises, education, and the exercise of public functions and places a duty on public authorities to promote equality of opportunity between men and women, and to prohibit sex discrimination in the exercise of public functions.

The Human Rights Act 1998 (schedule 1 article 12)
Sets out the right to enjoy all the freedoms and rights in the Act without discrimination on the grounds of race, sex, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. It is not a ‘free-standing’ right but has effect within the scope of all the rights in the convention.

3.2.6 Institutional Abuse
Institutional abuse can take any of the forms of abuse detailed above and individual perpetrators can be pursued under the previously mentioned legislation.

Mental Health Act 1983
Ill treatment of patients (s127 MHA 1983). It is an offence for any person who is a staff member or otherwise employed in or who is one of the managers of a hospital or nursing home to-

- Wilfully neglect or ill-treat a patient whilst an inpatient receiving treatment for their mental disorder
- Ill-treat or wilfully neglect, on the premises of the hospital or home a patient receiving treatment there on an outpatient basis.

The section makes it an offence to ill treat or wilfully neglect a person subject to guardianship or supervised discharge order.
Care Standards Act 2000

**Inspection of Homes** provisions empower authorised staff from CSCI to enter and inspect premises that are used for the purposes of residential care. If care is thought to be failing, a number of measures are available including:

- Prosecution of individuals
- Cancellation of registration
- Immediate closure of home, by order of a magistrate
- Restrictions on new admissions.

### 3.2.7 Other Legal Options – General

#### Criminal Injuries Compensation Claims

The Criminal Injuries Compensation Scheme takes applications for compensation, if as a result of a violent crime either physical and/or psychological injury has occurred. The scheme is based upon a tariff of payments for particular injuries. The incident of violence must have been reported to the police and the claim to CICA should be made within 2 years. This requires a solicitor, in most cases, to access.

#### Civil Claims

The law of tort enables a person to sue where he or she has suffered because of the acts or omissions of another person. Examples of civil claims are:

**Negligence**

A person is required to exercise a duty of care in his or her actions towards other people who might be affected by their acts or omissions. If a breach results in a loss or injury to another person, that other person may be entitled to compensation for loss or injury sustained.

**Trespass to the person or property**

Damages for compensation can be claimed where the acts by a person that constitute physical abuse cause injuries to another person or to another’s property or possessions.

#### Family Law Act 1996 Injunctions

Part iv deals with rights to occupy the matrimonial home, occupation orders, non-molestation orders. It repeals previous legislation on injunctions and provides one set of remedies available in court with family jurisdiction. Breach of Non molestation Orders is now a criminal offence.

#### Inherent Jurisdiction

The court will expect the Local Authority (LA) to have exhausted all persuasive and other means of affecting change before applying for inherent jurisdiction. The high court, will in the case of a vulnerable adult who ‘lacks capacity’, make a declaration as to whether the action proposed is in the best interests of the vulnerable adult. It is rarely used as it is expensive and time intensive but can provide a safe place to live for vulnerable adults lacking capacity who are at serious risk remaining in their existing home.

#### Guardianship (Section 7 of Mental Health Act 1983)

The Council with Social Services Responsibilities can receive a vulnerable adult into guardianship. Guardianship confers no financial powers.
The grounds for Guardianship are essentially that:

- The person is suffering from a mental disorder, being mental illness, mental impairment, severe mental impairment or psychopathic disorder, of a nature or degree which warrants reception into Guardianship AND

- reception into Guardianship is necessary in the interests of the welfare of the ‘patient’ or for the protection of others.

The powers afforded are very specific:

- to require the person to reside at a specific place
- to require to attend places for treatment, education or occupation
- to require access to a person to be given. (It is a criminal offence to prevent this.)

There are complications in executing Guardianship, especially where the nearest relative, as defined in the Act, objects, or if the vulnerable adult is resistant. However, if it appears that the grounds may be met, and that the powers may be of help, then this should be considered by discussion with an Approved Social Worker or manager of the Mental Health Social Work Team.

**Human Rights Act 1998**

Under the HRA if a court finds that an act is unlawful, it may remedy it in a just way including awarding damages. Proceedings must be brought within a year of the act complained of. The following are particularly relevant to safeguarding adults.

Article 2 – The right to life. In Pretty v UK 2002 EHRR the court indicated that the right to life is not a right to self-determination to choose death rather than life. However, it is compatible with the right to life for an NHS Trust to withdraw nutrition and hydration and an individual with adequate capacity may refuse medical treatment without this being a breach of Article 2.

Article 3 – The right not to be subjected to torture or to inhuman or degrading treatment or punishment. The threshold for breach is lower for those who are vulnerable. There is a positive duty on the state to protect vulnerable adults from abuse. There is a positive obligation for an independent open investigation where abuse has been suffered by an individual in the care of a public authority and a duty to take reasonable steps to prevent that ill treatment.

Article 5 – The right to liberty. No one shall be deprived of liberty unless he comes within one of the exemptions to the Article and the deprivation is in accordance with a procedure prescribed by law. The exemptions include lawful arrest or detention as part of the criminal process for dealing with offenders. Every individual deprived of liberty is entitled to take proceedings to have the lawfulness of the detention determined by a court.

Article 6 – The right to a fair hearing before an independent and impartial tribunal within a reasonable time to determine civil rights and obligations or any criminal charge.

Article 8 – The right to respect for private and family life, home and correspondence. It is qualified in that there should be no interference except where it is in accordance with the law and is necessary in a democratic society. The court must strike a balance between the general interest of the community and the interest of the individual.
3.2.8 Domestic Violence

**Domestic Violence Crime and Victims Act 2004**

Safeguarding Adults work has many parallels with the responses available to Domestic Violence and this legislation may be applicable. ‘Vulnerable adult’ in this Act means a person aged 16 or over whose ability to protect themselves from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise (section 5(6)). This is a different definition from those contained in ‘No Secrets’ and in the Care Standards Act 2000.

Measures in the Act include:

- new police powers to deal with domestic violence including making a breach of a non-molestation order a criminal offence, with a 5-year prison penalty.
- stronger legal protection for victims by extending the use of restraining orders - giving courts power to impose a restraining order where the defendant has been acquitted but the court believes an order is necessary to protect the victim.
- providing a code of practice, binding on all criminal justice agencies, so that all victims receive the support, protection, information and advice they need.
- allowing victims to take their case to the Parliamentary Ombudsman if they feel the Code has not been adhered to by the criminal justice agencies.
- amending the Protection from Harassment Act 1997 to ensure that victims have their say if an application is made to change a restraining order that is protecting them from abuse or harassment.
- strengthening the civil law on Domestic Violence so that cohabiting same-sex couples have the same protection as heterosexual couples, and extending the availability of non-molestation orders to couples who have never lived together or have never been married.
- creating a new offence of familial homicide for causing or allowing the death of child or vulnerable adult.
- reform to defences to homicide - including provocation.

3.2.9 General Police Powers

**The Police and the Criminal Evidence Act 1984 (as amended)**

Section 17 gives powers to the police to enter and search premises without a warrant for the purpose of saving life or limb.

Section 24 allows a police officer to arrest any person who is suspected of having committed or is about to commit an offence or allows the police, where there are reasonable grounds, to make an arrest of someone to prevent them causing physical injury to another person or to protect a child or vulnerable adult.

3.2.10 Achieving Best Evidence

**Youth Justice and Criminal Evidence Act 1999**

‘Speaking Up for Justice’ [Home Office 1998] recommended extending the existing special measures introduced for child witnesses to vulnerable or intimidated adults, together with a range of other measures from the investigation stage, through to the trial and beyond. Provisions to implement those recommendations requiring legislation were included in Part II of the 1999 Youth Justice and Criminal Evidence Act.

Not all adults with disabilities will necessarily be vulnerable as witnesses and would not wish to be treated as such. This is recognised in the definitions and criteria contained in the Act.
Those adults who are eligible for consideration for Special Measures fall into two groups, defined in sections 16 and 17 of the 1999 Act. The first group comprises those who have a disability or illness that the court considers is likely to affect the quality of their evidence. The second group consists of those who because of age, personal circumstance and the nature of the alleged offence, may also qualify for Special Measures if the court is satisfied that the quality of their evidence is likely to be diminished by reason of their fear or distress.

In reaching a decision on whether the Special Measures should be invoked, the courts must take account of the wishes of the individual witness. It is imperative therefore that investigators establish at an early stage whether the vulnerable adult is likely to qualify for a Special Measures direction under the 1999 Act and if so, what particular measures, if any, will assist the witness to maximise the quality of their evidence. This will need to be discussed with the vulnerable adult to ascertain their views.

Special Measures available:
• Any measure that the person or their advocate believes will assist them to be involved in the justice process, provided the CPS and court agree
• DVD interview in chief
• DVD cross examination – no date for implementation
• Live TV link (automatic if DVD interviewed)
• Evidence in private
• Examination by intermediary
• Communication aids
• Removal of wigs and gowns
• Clearing of the courtroom
• Mandatory protection from cross-examination by the accused in sexual offences cases
• Discretionary protection from cross examination by the accused
• Restrictions on evidence and questions about the complainants’ sexual behaviour.

3.2.11 Forced marriage
The Forced Marriage (Civil Protection) Bill had its Second Reading in the House of Lords on 26 January 2007 The Bill’s key prohibition is that ‘a person must not act in a way which he knows amounts to:
  a) forcing or attempting to force another person to enter into a marriage or a purported marriage without that other person’s free and full consent, or
  b) practising a deception for the purpose of causing another person to enter into a marriage or a purported marriage without that other person’s free and full consent.’

The Bill makes provision, among other things, with respect to:
• unlawful inducement of acts leading to forced marriage;
• aiding and abetting forced marriage;
• orders for injunctions to prevent forced marriage; and
• civil proceedings and damages.

The Bill contains civil remedies for forced marriage rather than criminal sanctions, although the court may attach a power of arrest to the order for injunction or to certain provisions of the order if it appears to the court that the respondent has used or threatened violence against the person who is or may be the victim of the conduct in question.
3.3 What Constitutes Abuse?

‘Abuse is a violation of an individual’s human and civil rights by any other person or persons.’ [No Secrets’ DH 2000]

3.3.1 Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological. It may be an act of neglect or an omission to act, or it may happen when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent.

3.3.2 Abuse can happen in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. For information about assessing significant harm, see section 2.3.

An accepted definition of significant harm is:
‘…ill-treatment (including sexual abuse and forms of ill treatment that are not physical); the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, emotional, social or behavioural development’. [Law Commission 1995]

3.4 Signs and Indicators of abuse

3.4.1 Please note that these indicators are a guide only. All situations must be discussed with the appropriate line manager. A full investigation and assessment is required to establish the existence of abuse leading to the significant harm of a vulnerable adult. Typically an abusive situation will involve indicators from a number of groups in combination.

3.4.2 Physical Abuse
Physical injuries which have no satisfactory explanation or where there is a definite knowledge, or a reasonable suspicion that the injury was inflicted with intent, or through lack of care, by the person having custody, charge or care of that person, including hitting, slapping, pushing, misuse of or lack of medication, restraint, or inappropriate sanctions.
Possible Indicators of physical abuse
- History of unexplained falls or minor injuries
- Unexplained bruising – in well protected areas, on the soft parts of the body or clustered as from repeated striking
- Unexplained burns in an unusual location or of an unusual type
- Unexplained fractures to any part of the body that may be at various stages in the healing process
- Unexplained lacerations or abrasions
- Slap, kick, pinch or finger marks
- Injuries/bruises found at different stages of healing for which it is difficult to suggest an accidental cause
- Injury shape similar to an object
- Untreated medical problems
- Weight loss – due to malnutrition or dehydration; complaints of hunger
- Appearing to be over medicated

3.4.3 Psychological Abuse
Psychological, or emotional abuse, includes the use of threats, fears or bribes to negate a vulnerable adult’s choices, independent wishes and self esteem; cause isolation or over-dependence (as might be signalled by impairment of development or performance); or prevent a vulnerable adult from using services, which would provide help.

Possible Indicators of psychological abuse
- Ambivalence about carer
- Fearfulness expressed in the eyes; avoids looking at the carer, flinching on approach
- Deferece
- Overtly affectionate behaviour to alleged perpetrator
- Insomnia/sleep deprivation or need for excessive sleep
- Change in appetite
- Unusual weight gain/loss
- Tearfulness
- Unexplained paranoia
- Low self-esteem
- Excessive fears
- Confusion
- Agitation

3.4.4 Sexual Abuse
Sexual acts which might be abusive include non-contact abuse such as looking, pornographic photography, indecent exposure, harassment, unwanted teasing or innuendo, or contact such as touching breasts, genitals, or anus, masturbation, penetration or attempted penetration of vagina, anus, mouth with or by penis, fingers or other objects.
Possible Indicators of sexual abuse

- A change in usual behaviour for no apparent or obvious reason
- Sudden onset of confusion, wetting or soiling
- Withdrawal, choosing to spend the majority of time alone
- Overt sexual behaviour/language by the vulnerable person
- Self-inflicted injury
- Disturbed sleep pattern and poor concentration
- Difficulty in walking or sitting
- Torn, stained, bloody underclothes
- Love bites
- Pain or itching, bruising or bleeding in the genital area
- Sexually transmitted urinary tract/vaginal infections
- Bruising to the thighs and upper arms
- Frequent infections
- Severe upset or agitation when being bathed/dressed/undressed/medically examined
- Pregnancy in a person not able to consent

3.4.5 Financial Abuse

This usually involves an individual's funds or resources being inappropriately used by a third person. It includes the withholding of money or the inappropriate or unsanctioned use of a person’s money or property or the entry of the vulnerable adult into financial contracts or transactions that they do not understand, to their disadvantage.

Possible Indicators of financial abuse

- Unexplained or sudden inability to pay bills
- Unexplained or sudden withdrawal of money from accounts
- Person lacks belongings or services, which they can clearly afford
- Lack of receptiveness to any necessary assistance requiring expenditure, when finances are not a problem – although the natural thriftiness of some people should be borne in mind
- Extraordinary interest by family members and other people in the vulnerable person’s assets
- Power of Attorney obtained when the vulnerable adult is not able to understand the purpose of the document they are signing
- Recent change of deeds or title of property
- Carer only asks questions of the worker about the user’s financial affairs and does not appear to be concerned about the physical or emotional care of the person
- The person who manages the financial affairs is evasive or uncooperative
- A reluctance or refusal to take up care assessed as being needed
- A high level of expenditure without evidence of the person benefiting
- The purchase of items which the person does not require or use
- Personal items going missing from the home
- Unreasonable and/or inappropriate gifts
3.4.6 Neglect / Acts of Omission
Neglect can be both physical and emotional. It is about the failure to keep a vulnerable adult clean, warm and promote optimum health, or to provide adequate nutrition, medication, being prevented from making choices.

Neglect of a duty of care or the breakdown of a care package may also give rise to safeguarding issues i.e. where a carer refuses access or if a care provider is unable, unwilling or neglects to meet assessed needs. If the circumstances mean that the vulnerable adult is at risk of significant harm, then Safeguarding Adults procedures should be invoked.

Possible Indicators of neglect
- Poor condition of accommodation
- Inadequate heating and/or lighting
- Physical condition of person poor, e.g. ulcers, pressure sores etc.
- Person’s clothing in poor condition, e.g. unclean, wet, etc.
- Malnutrition
- Failure to give prescribed medication or appropriate medical care
- Failure to ensure appropriate privacy and dignity
- Inconsistent or reluctant contact with health and social agencies
- Refusal of access to callers/visitors

A person with capacity may choose to self-neglect, and whilst it may be a symptom of a form of abuse it is not abuse in itself within the definition of these procedures.

3.4.7 Discriminatory Abuse
This is abuse targeted at a perceived vulnerability or on the basis of prejudice including racism or sexism, or based on a person's disability. It can take any of the other forms of abuse, harassment, slurs or similar treatment.

Discriminatory abuse may be used to describe serious, repeated or pervasive discrimination, which leads to significant harm or exclusion from mainstream opportunities, provision of poor standards of health care, and/or which represents a failure to protect or provide redress through the criminal or civil justice system.

Possible Indicators of discriminatory abuse
- Hate mail
- Verbal or physical abuse in public places or residential settings
- Criminal damage to property
- Target of distraction burglary, bogus officials or unrequested building/household services

3.4.8 Institutional Abuse
Institutional abuse happens when the rituals and routines in use force residents or service users to sacrifice their own needs, wishes or preferred lifestyle to the needs of the institution or service provider.
Abuse may be perpetrated by an individual or by a group of staff embroiled in the accepted custom, subculture and practice of the institution or service.

**Possible indicators of institutional abuse**
- Institutions may include residential and nursing homes, hospitals, day centres, sheltered housing schemes, group or supported housing projects. It should be noted that all organisations and services, whatever their setting, can have institutional practices which can cause harm to vulnerable adults.
- It may be reflected in an enforced schedule of activities, the limiting of personal freedom, the control of personal finances, a lack of adequate clothing, poor personal hygiene, a lack of stimulating activities or a low quality diet – in fact, anything which treats service users as not being entitled to a ‘normal’ life.

The distinction between abuse in institutions and poor care standards is not easily made and judgements about whether an event or situation is abusive should be made with advice from appropriate professionals and regulatory bodies.

### 3.5 Predisposing Factors

3.5.1 Abuse can happen in a range of settings, in a variety of relationships and can take a number of forms. There are a number of indicators, which could, in some circumstances, in combination with other possibly unknown factors, suggest the possibility of abuse. Abuse may be more likely to happen in the following situations:

3.5.2 Environmental Problems – overcrowding/poor housing conditions/lack of facilities.

3.5.3 Financial Problems – low income and a dependent vulnerable adult may add to financial difficulties, inability to work due to caring role, debt arrears, full benefits not claimed.

3.5.4 Psychological and Emotional Problems – family relationships over the years have been poor and there is a history of abuse in the family or where family violence is the norm.

3.5.5 Communication Problems – the vulnerable person or their carer has difficulty communicating due to sensory impairments, loss or difficulty with speech and understanding, poor memory or other conditions resulting in diminished mental capacity; this also includes people for whom English is a second language.

3.5.6 Dependency Problems – increased dependency of the person, major changes in personality and behaviour, carers are not receiving practical and/or emotional support.

Organisational culture – services which are inward looking, where there is little staff training/knowledge of best practice and where contact with external professionals is resisted, increase the vulnerability of service users. High staff turnover or shortages may also increase the risk of abuse.
3.6 Patterns of abuse
Patterns of abuse and abusing vary and reflect very different dynamics. These include:

3.6.1 Serial abuse in which the perpetrator seeks out and ‘grooms’ vulnerable adults. Sexual abuse may fall into this pattern, as do some forms of financial abuse.

3.6.2 Long term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations.

3.6.3 Opportunist abuse such as theft happening because money has been left around.

3.6.4 Situational abuse which arises because pressures have built up and/or because of difficult or challenging behaviour.

3.6.5 Neglect of a person’s needs because those around him or her are not able to be responsible for their care, for example if the carer has difficulties attributable to such issues as debt, alcohol or mental health problems.

3.6.6 Stranger Abuse where vulnerable adults can be targeted by strangers; this may be an individual, a gang, or people offering services (e.g. the conman who tells the older person he will repair their roof, taking a large amount of money but actually doing nothing). Different forms of abuse can be inflicted in these situations e.g. financial, physical, emotional. ‘No Secrets’ states that:

‘Stranger abuse will warrant a different kind of response from that appropriate to abuse in an ongoing relationship or in a care location. Nevertheless, in some instances it may be appropriate to use the locally agreed inter-agency adult protection procedures to ensure that the vulnerable person receives the services and support that they need. Such procedures may also be used when there is the potential for harm to other vulnerable people.’

3.7 Risk Assessment and Management
3.7.1 Risk assessment and risk management are essential aspects of protection of vulnerable adults from abuse. They must be included in the measures taken to prevent abuse, as well as being an integral part of the protection plan in response to actual allegations or suspicions of abuse.

3.7.2 Risk assessments are undertaken by a variety of social care and health professionals. They may encompass different assessment tools and be recorded in a variety of formats. Workers should follow organisational policies and share the results in accordance with the Safeguarding Adults Information Sharing Protocol.

3.7.3 In assessing the seriousness of the risk of abuse, the following should be considered:
• the vulnerability of the individual:
  - the extent of any cognitive impairment
  - their level of physical dependency
  - their level of emotional dependency
  - their level of financial dependency
  - their ability to communicate
  - their level of social / cultural isolation
• the nature and extent of the abuse
• the length of time over which the abuse has been happening
• the impact on the individual
• the impact on others
• whether the situation can be monitored.

3.7.4 In assessing the likelihood of an abusive incident reoccurring, the following should be considered:
• whether there is a history of abuse or domestic violence
• the intent of the perpetrator - was it a deliberate act or lack of awareness?
• the existence of known predisposing factors or triggers
• the supportive measures that can be put in place
• whether the situation can be monitored.

3.7.5 The risk should be considered high if:
• there is reason to believe that someone's life may be in danger
• there is reason to believe that major injury or serious physical or mental ill health could result
• the incidents are increasing in frequency
• the incidents are increasing in severity
• the behaviour is persistent and / or deliberate.

3.8 Capacity, Consent and Decision Making
3.8.1 The consideration of capacity is crucial at all stages of Safeguarding Adults procedures. For example determining the ability of a vulnerable adult to make lifestyle choices, such as choosing to remain in a situation where they risk abuse; determining whether a particular act or transaction is abusive or consensual; or determining how much a vulnerable adult can be involved in making decisions in a given situation.

3.8.2 The key development affecting this area of work is the implementation of the Mental Capacity Act 2005, which provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. It makes it clear who can take decisions in which situations and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

3.8.3 Guidance on the Act is provided in a statutory Code of Practice, and Training provided as part of its implementation see www.justice.gov.uk/guidance/mca-code-of-practice.htm

Further information on local arrangements can be found in section 4 of this document.
3.8.4 The whole Act is underpinned by a set of five key principles:

- **A presumption of capacity** - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
- The right for individuals to be **supported to make their own decisions** - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
- That individuals must retain the right to make what might be seen as eccentric or **unwise decisions**;
- **Best interests** - anything done for or on behalf of people without capacity must be in their best interests; and
- **Least restrictive intervention** - anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

Mental Capacity Act 2005 sections 2 (1), Code of Practice 4.11 – 4.13
Section 2 states that a person lacks capacity in relation to a matter if at the material time s/he is unable to make a decision for himself or herself in relation to the matter because of an impairment of or a functioning of the mind or brain.

Mental Capacity Act 2005 section 3, Code of Practice 4.49 – 4.54
Section 3 states that a person is unable to make a decision if s/he is unable
- To understand the information relevant to the decision
- To retain the information
- To use or weigh that information as part of the process of making the decision
- To communicate his decision by any means.

Every assessment of capacity must be undertaken in accordance with the Act and provisions of the Code of Practice. Where there is a reasonable belief that a person lacks capacity, there is a statutory best interests checklist for people acting on behalf of others. The decision maker must work through the factors when deciding what is in the best interests of the individual.

3.8.5 The Act deals with two situations where a designated decision-maker can act on behalf of someone who lacks capacity

- **Lasting powers of attorney** (LPAs) - The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This is similar to previously available Enduring Power of Attorney (EPA), but the Act also allows people to let an attorney make health and welfare decisions.
- **Court appointed deputies** - The Act provides for a system of court appointed deputies to replace the current system of receivership in the Court of Protection. Deputies will be able to take decisions on welfare, healthcare and financial matters as authorised by the Court but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues.

3.8.6 The Act creates two new public bodies to support the statutory framework, both of which will be designed around the needs of those who lack capacity.

- **A new Court of Protection** - The new Court has jurisdiction relating to the whole Act and will be the final arbiter for capacity matters. It has its own procedures and nominated judges.
A new Public Guardian - The Public Guardian and his/her staff are the registering authority for LPAs and deputies. They supervise deputies appointed by the Court and provide information to help the Court make decisions. They also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board scrutinises and reviews the way in which the Public Guardian discharges his/her functions. The Public Guardian is required to produce an Annual Report about the discharge of his/her functions.

3.8.7 The Act also includes further key provisions to protect vulnerable people

• Advance decisions to refuse treatment
Statutory rules with clear safeguards confirm that people may make a decision in advance to refuse treatment if they should lose capacity in the future. It is made clear in the Act that an advance decision will have no application to any treatment, which a doctor considers necessary to sustain life, unless strict formalities have been complied with. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands ‘even if life is at risk’.

• A criminal offence
The Act introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

• Independent Mental Capacity Advocate (IMCA)
The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

The Department of Health has extended the Act through Regulations to cover circumstances where a Safeguarding Adults allegation has been made. The Regulations specify that Local Authorities and the NHS have powers to instruct an IMCA if the following requirements are met:
• where safeguarding measures are being put in place in relation to the protection of vulnerable adults from abuse; and
• where the person lacks capacity.

In these circumstances the Local Authority or NHS body may instruct an IMCA to represent the person concerned, if it is satisfied that it would be of benefit for the person to do so.

In Safeguarding Adults cases access to IMCAs is not restricted to people who have no one else to support or represent them. People who lack capacity who have family and friends can still have an IMCA to support them through the safeguarding process.

The regulations equally apply to a person who may have been abused or neglected and a person who is alleged to be the perpetrator.
Where the qualifying criteria are met, it would be unlawful for the Local Authority or the NHS not to consider the exercise of their power to instruct an IMCA for Safeguarding Adults cases.

- **Restraint**
  Section 5 permits the use of restraint if the person using it reasonably believes that it is necessary to prevent harm to the incapacitated person and if the restraint is proportionate to the likelihood and seriousness of harm. But section 6(5) confirms that there is no protection under the Act for actions that result in someone being deprived of their liberty as defined by Article 5 (1) HRA 1998.

### 3.9 Human Resource Issues

**Disciplinary Action.**

3.9.1 If a member of staff is alleged to have abused a vulnerable adult then it is important that any disciplinary investigation is conducted alongside the Safeguarding Adults investigation, any police investigation, Healthcare Commission Investigation and any enforcement action carried out by the CSCI.

3.9.2 The Disciplinary procedure is separate from the other forms of investigation but coordination and the sharing of information is essential. **Criminal investigations must have primacy over other enquiries**, but does not preclude the progression of disciplinary procedures if agreed through the Safeguarding Strategy.

3.9.3 The conduct of an investigation under a disciplinary procedure should not prevent the investigation of the allegation by the police, registering authorities or Safeguarding Adults procedures.

3.9.4 Consideration should be given to whether suspension from duty is required. Suspension should not be seen as an indication of guilt but can ensure the alleged victim and perpetrator are safe pending further investigations.

3.9.5 In circumstances where there is a decision not to suspend the reasons must be documented so they are available as evidence if required for the Police, Safeguarding Adults investigator and CSCI/Healthcare Commission in regulated settings.

3.9.6 Consideration should also be given to whether the alleged perpetrator needs to be referred for inclusion on the POVA list.

3.9.7 Consideration should also be given as to whether the alleged perpetrator is governed by codes of professional conduct and/or employment contracts which will determine the action that can be taken against them. Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation.

3.9.8 None of the above affects the victim’s rights to pursue a civil claim against a staff member or employing agency.
3.9.9 Support for the Alleged Perpetrator
• Support for the alleged perpetrators must be identified and agreed.
• If suspended, contact with the staff member should be maintained as necessary by the relevant manager and/or the Human Resources Department. This should not involve discussing the details of the alleged abuse but should focus on ensuring that the staff member understands the procedures and is kept up to date with any other pertinent organisational information.
• Advice should be given on how to contact external support groups including trades unions.

3.9.10 Staff Raising Concerns / Whistleblowing
The Public Interest Disclosure Act 1998 sets out requirements for organisations to have procedures under which staff can raise concerns they have and do not feel they can raise another way. In most circumstances staff can report concerns about potential abuse of a vulnerable adult to their manager. However, in certain circumstances they may feel unable to do this if:
• the concern involved their manager
• previous concerns had not been acted on.

3.9.11 It can be very difficult for staff to raise concerns outside their workplace, as they may worry about damaging their future career prospects and their relationships with colleagues. All agencies must have procedures in place to enable staff to raise concerns and foster a culture that encourages and supports staff to do so.

3.9.12 Staff and volunteers should be informed of their right to protection from victimisation, under The Public Interest Disclosure Act 1998, if they do raise concerns. Staff can contact Public Concern at Work 020 7404 6609 for further advice.

3.9.13 Support for Staff Members Reporting Alleged Abuse.
• Managers must ensure that all staff are aware of whistle blowing procedures. Support for the person reporting the alleged abuse should be identified and agreed.
• Staff should be reassured that they did the right thing in reporting their concerns and that they are not responsible for any subsequent consequences faced by the perpetrator.
3.10 POVA/vetting and barring

3.10.1 Protection Of Vulnerable Adults
The Protection of Vulnerable Adults scheme was introduced on 26 July 2004 under the Care Standards Act 2000 to protect vulnerable adults aged 18 years and over in care settings in both England and Wales. At its heart is the POVA list operated by the Department for Education and Skills (DfES) on behalf of the Secretary of State for Health (DH). Through referrals to and checks against the list, care workers who have harmed, or who have risked harm to, a vulnerable adult are banned from working in a care position with vulnerable adults. In addition, links are made by the Secretary of State to the Protection of Children Act (POCA) list, also administered by DfES.

In addition to the Criminal Records Bureau check, employers – including voluntary and adult placement managers – are required to check the POVA list when recruiting workers, carers or volunteers in regular contact with vulnerable adults. They are also required to make a referral to the list whenever they have decided that, in their view, a worker, carer or volunteer is suspended and when reasonably considered to be guilty of misconduct that has harmed or placed a vulnerable adult at risk of harm and they have suspended, dismissed or moved that person to a non-care position.

It is an offence for people confirmed on the list knowingly to apply for, offer to do, accept or do any work in a paid or unpaid caring position. Anyone employing them will be in breach of regulations relating to fitness of staff.

The list covers care workers, including volunteers and adult placement carers, who are working with vulnerable adults aged 18 years or over in:
• registered care homes
• registered domiciliary care agencies
• registered adult placement schemes.
It does not cover NHS or other independent services or direct payments users unless they employ carers through an agency.

3.10.2 Vetting and Barring
In response to recommendation 19 of the Bichard Inquiry, the Government is planning to introduce a new vetting and barring scheme for people who work with children and vulnerable adults. The aim of the vetting and barring scheme is to reduce the incidence of harm to children and vulnerable adults by helping to ensure that:
• employers benefit from an improved vetting service for those who work with children and/or vulnerable adults;
• those who are known to be unsuitable are barred from working with children and/or vulnerable adults at the earliest possible opportunity.
The new scheme will:
• build on the existing lists of those barred from work with children and vulnerable adults, including the Protection of Vulnerable Adults (POVA) list;
• be more comprehensive in coverage, with a wider workforce eligible for checks;
• enable a barring decision to be made on the basis of an individual’s criminal record history, as well as following a referral from an employer or another body;
• update barring decisions as soon as any new information is made available and notify employers if an employee is deemed unsuitable;
• enable employers to make secure, instant online checks of an applicant’s status in relation to the scheme.

Safeguarding Vulnerable Groups Act
The Safeguarding Vulnerable Groups Bill received Royal Assent on 8 November 2006; the Vetting and Barring processes will be phased in from Autumn 2008.
3.11 Information Sharing Protocol

3.11.1 Aim
To facilitate and provide clear guidance on the exchange of personal and sensitive information for the investigation and responding to suspected abuse and neglect of adults within South Yorkshire. Signatory organisations to the Safeguarding Adults Procedures and Policy have already committed to working together on the identification, investigation, treatment and prevention of abuse or mistreatment of vulnerable adults. This protocol will provide a clear basis for operational staff to improve information exchanges to support earlier identification, prevention, investigation and treatment of abuse of vulnerable adults.

3.11.2 Background
‘No Secrets’ [DH 2000] says that the government expects organisations to be sharing information about individuals who may be at risk from abuse. It is important to identify an abusive situation as early as possible so that the individual can be protected. Withholding information may lead to abuse not being dealt with early enough. Confidentiality must never be confused with secrecy.

Investigating and responding to suspected abuse or neglect requires close co-operation between a range of disciplines and organisations. Safeguarding Adults work is concerned with sharing ‘personal information’, both about someone who is alleged to have experienced abuse and an alleged perpetrator.

3.11.3 Scope of the Protocol
This protocol applies to information sharing in relation to situations involving vulnerable adults who meet the criteria for Safeguarding Adults interventions: any adult ‘who is or may be eligible for community care services’ and ‘whose independence and wellbeing is at risk due to abuse or neglect’. The protocol applies to all organisations with responsibilities for the provision of either assessments or services under the Safeguarding Adults Procedures and Policy.

Non-partner organisations are not precluded from involvement in the information sharing process, including Safeguarding Case Conferences. The contact person within a non-partner organisation should be a senior member of staff and the information shared would be specifically relevant to that organisation’s function and statutory powers.

3.11.4 Purpose of information sharing
The information exchanged under this protocol will only be used for Safeguarding Adults purposes and where it meets these conditions:
- a criminal offence has taken place
- it may prevent crime
- the alleged victim is at risk of harm
- staff, other service users, or the general public may be at risk of harm
- for early intervention and identification of abuse
- for investigations under Safeguarding Adults procedures.

This protocol has been approved only for the purposes listed above.
If other reasons for sharing information are subsequently identified, these will be considered and amendments approved by the appropriate Caldicott Guardians of the partner organisations. The parties to the agreement may share information for other purposes as stipulated in other Service Level Information Sharing Protocols.

3.11.5 Information sharing when the vulnerable adult has given consent

There are situations where information can be shared legally without obtaining the consent from an individual. An element of information sharing will need to happen as part of the Strategy Meeting/discussion where initial assessments of the risk factors affecting a potentially vulnerable adult are made.

In this situation information can be shared without consent, relying upon statutory powers and duties. As part of the Strategy meeting the following decisions will be made:
- any legal requirement to gain consent
- when and who will gain consent if required.

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

Informed consent is a freely-given specific and informed indication of a person’s agreement to a course of action where information is given to that person about the proposed course of action. It may be expressed verbally or in writing (except where an individual cannot write or speak when other forms of communication may be sufficient). Consent may be given in the form of an advanced statement.

Workers need to make sure that the vulnerable adult understands what will be recorded, what the information will be used for and with whom it might be shared. If the worker does not explain this, they will not be able to give valid informed consent for information sharing to take place. The following information should be recorded clearly within their own organisation’s record when consent to share information has been freely given:
- why the information needs to be shared
- what information the service user has consented to be shared
- who the service user has consented for the information to be passed to, and any limitations to this
- that this has been explained to the service user and they understand the implications of giving consent to share their information
- any comments made by the service user in relation to the disclosure
- date consent given
- decisions to refer/not to refer.

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

Information given to an individual member of staff, or organisation representative, belongs to the organisation not that member of staff. Personal information shared with a worker in the course of their employment is:
• confidential to the employing organisation and can be shared within that organisation
• should only be used for the purposes for which it was intended
• can be shared with another organisation either when:
  • permission is given by the person about whom the information is held
  • there is an overriding justification, statutory power or duty to share information without
    the person's consent.

3.11.6 Information sharing when the service user/vulnerable adult does not have the capacity to consent to information sharing
Upon reaching the age of 18, no one else can take decisions on their behalf. If an adult is not competent to take their own decisions, professionals should share information that is in their ‘best interests’. The capacity to be able to give consent can be assessed by considering:
• has the person got the ability or power to make a particular decision
• have they got the ability to understand and retain the information relevant to the decision
• will they be able to understand the reasonably foreseeable consequences of deciding one way or the other
• will they have the ability to communicate the decision they have come to.

Where a person is not the legal representative but acts as 'carer' to a person not capable of giving consent, we have to consider whether they are acting on their behalf and in the individual’s best interests. As long as the individual’s rights are not adversely affected and we act in the best interests of that individual, we have to get the best form of consent we can at the time a decision has to be made.

3.11.7 Best Interest

The Mental Capacity Act 2005 (section 4) and The Code of Practice set out the best interests checklist to which professionals must have regard when determining what is in the best interests of an individual.

Where a vulnerable adult is judged to lack capacity in relation to a specific decision, this decision should be made in their ‘best interests’.

In the context of determining whether or not medical treatment should be provided to someone who lacks capacity, the House of Lords has defined best interest as an intervention which is:

‘Necessary to save life or prevent a deterioration or ensure an improvement in the patient’s physical or mental health; and in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question.’
(Code of Practice: Mental Health Act 1983)

In other aspects of decision making, particularly in relation to information sharing, the law is less clear. However, the Law Commission has recommended that in deciding what is in a person's best interests consideration should be given to the following:
1. Ascertainable past and present wishes and feelings of the person concerned and the factors the person would consider if able to do so.
2. The need to encourage the person to participate as fully as possible in decisions.
3. The views of other people whom it is appropriate and practical to consult about the person’s wishes and feelings and what would be in their best interests.
4. Any person named by the client as someone to be consulted on those matters.
5. Anyone (whether a spouse, relative, friend or other person) engaged in caring for the client or interested in the client’s welfare.
6. The holder of any continuing power of attorney.
7. Any manager appointed for him by the court.
8. Achieving the purpose of an action or decision by means which least restrict the freedom of action of the person.
9. If someone is unable to give consent and there is no-one to represent them, we should record that they cannot give consent and only share information where necessary in their best interests or where we have a statutory duty to provide care.
10. If an adult is unable to give informed consent, then decisions to disclose information will generally be taken by the professional concerned. Any decision should take into account the person’s best interests and as necessary the views of relatives and carers. An earlier refusal to particular information being passed on, given while the person had capacity to decide, should normally be regarded as decisive.
11. Where a service user’s capacity may change from day to day (for example as a consequence of fluctuating mental health), a decision on consent should be deferred wherever possible, until such a time as they are able to be involved in the decision making process, as long as this does not adversely impact on the vulnerability of the adult.
12. Where it is considered that a service user does not have the capacity, a record should be made of this decision and the steps taken by the professional to reach a decision about whether information should be shared.

3.11.8 Information sharing when the vulnerable adult withholds consent to share information

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

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

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

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

Decisions to share without consent must make sure that it does not interfere with that person’s human rights.
3.11.9 Sharing information with carers, parents, family, partners etc
When the vulnerable adult has the ‘capacity’ to make the decision, it should be up to them to decide what information is disclosed to their carers/parents/family/partners, and records should reflect this.

When the adult does not have the capacity, consideration should be given to when to share information with carers/parents of vulnerable adults. In addition, consideration must be given to the relationship between the cares/parents and the alleged abuser. Clear decisions should be recorded about when and what to share, and who is the most appropriate person to talk to the parent/carer etc. Generally some assessment should be made as to whether the sharing of certain information with a particular person or organisation is in the adult’s best interests.

3.11.10 Sharing Information with third parties about the (alleged) abuser
Organisations and workers must ‘honestly and reasonably believe’ that the sharing of information is necessary to protect a vulnerable adult or the wider public and must use the test of ‘pressing social need’. To pass this test the relevant organisation must consider the following issues:-
• How strong is the belief in the truth of the particular allegation? The greater the conviction that the allegation is true, the more compelling the need for disclosure.
• What is the interest of the third party in receiving the information? The greater the legitimacy of the interest in the third party in having the information, the more important need to disclose
• What is the degree of risk posed by the individual if disclosure is not made?

Decisions about who needs to know and what needs to be known should be taken on a case by case basis. It is vital there is a balancing exercise undertaken weighing the serious consequences of disclosure against risks to vulnerable adult. Clearly the issue of proportionality will be vital.

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

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

Caution should be exercised before making any such disclosure: it should be seen as an exceptional measure. The following check list may be of assistance:
• The individual presents a risk of serious harm to the vulnerable adult, or to those for whom the recipient of the information has responsibility. The right person will be the person who needs to know in order to avoid or prevent the risks.

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

• The risk to the individual should be considered although it should not outweigh the potential risk to others were disclosure not to be made. The individual retains his rights (most importantly his Article 2 right to life) and consideration must be given to whether those rights are endangered as a consequence of the disclosure.

• The disclosure is to the right person and that they understand the confidential and sensitive nature of the information they have received. The information will not be disclosed by the recipient third party without the express permission of the original disclosing organisation. Consider consulting the individual about the proposed disclosure. This should be done in all cases, unless to do so would not be safe or appropriate. If it is possible and appropriate to obtain the individual’s consent, then a number of potential objections to the disclosure are overcome. Equally, the individual may wish to leave the placement rather than have any disclosure made. If appropriate, this would also avoid the need for disclosure.

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

3.11.12 Access and Security
Access to personal information must be adequately protected from unauthorised or inappropriate access. Parties to this protocol must implement and maintain appropriate security measures to protect confidentiality, integrity and availability of personal information.

Adopted security measures must be effectively communicated to all staff and system users, detailing individual roles and responsibilities. System users must be provided with sufficiently detailed training to enable them to undertake their duties and maintain information security.
3.12 Recording paperwork

All Safeguarding Adults activity needs to be recorded and all organisations and workers have responsibilities for record keeping within their work.

The responsibility for collating and reporting data lies with ‘Councils with Social Service Responsibilities’ and this is co-ordinated by Adult Protection Offices.

Work is currently taking place to introduce a national collection system for data on Protection of Vulnerable Adults in order to:

• ensure that local authorities collect data on Protection of Vulnerable Adults referrals
• allow national conclusions to be drawn about efforts to protect vulnerable adults from abuse
• allow local authorities to draw comparisons on their performance with other ‘similar’ authorities
• encourage the development of National Standards on protecting vulnerable adults from abuse whilst retaining responsibility for implementing such standards at a local level
• encourage all agencies to fulfil their roles and responsibilities in this work as laid out by ‘No Secrets’ Guidance
• raise the profile of protection of vulnerable adults work at a local level.

It is intended that National Reporting Requirements are produced to meet these aims. As a matter of good practice in recording activity and outcomes, and for consistency across South Yorkshire, a common set of recording documents will be introduced:

• Safeguarding Adults Referral Form
• Safeguarding Adults Log Sheet/Monitoring Form
• Meeting attendance/signing-in sheet
• Safeguarding Strategy Agenda
• Safeguarding Strategy [meeting or discussion] Record/Minutes
• Safeguarding Case Conference Notification
• Convenor’s Report for Safeguarding Case Conference
• Multi-agency Report for initial Safeguarding Case Conference
• Consultation Form for Subject of a Safeguarding Case Conference or Review
• Safeguarding Case Conference Agenda and Guidance [Ground Rules and Criteria for identifying if abuse has occurred]
• Safeguarding Case Conference Record/Minutes
• Safeguarding Plan
<table>
<thead>
<tr>
<th>1. ALLEGED VICTIM INFORMATION</th>
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<tbody>
<tr>
<td><strong>Name:</strong></td>
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<td><strong>Current Address:</strong></td>
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<td>If living elsewhere,</td>
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<tr>
<td>State:</td>
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<tr>
<td><strong>GP:</strong></td>
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<tr>
<td><strong>Surgery Address:</strong></td>
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<tr>
<td>Is the person receiving Community Services?</td>
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<td>Give details if yes:</td>
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<tr>
<td>If person is in residential care please give previous home address:</td>
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<tr>
<td>Consent obtained for referral?</td>
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<table>
<thead>
<tr>
<th>2. SAFEGUARDING ADULTS REFERRAL MADE BY</th>
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<tr>
<td><strong>Name:</strong></td>
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<td><strong>Address:</strong></td>
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<td><strong>Contact Number:</strong></td>
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<tr>
<th>3. ALLEGED PERPETRATOR INFORMATION</th>
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<td><strong>Name:</strong></td>
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<td><strong>Address:</strong></td>
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<td><strong>Contact No:</strong></td>
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<tr>
<td>Is the person aware of referral?</td>
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</table>

**Safeguarding Form 1** – It is Important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
## SAFEGUARDING ADULTS 1a LOG SHEET

<table>
<thead>
<tr>
<th>DATES</th>
<th>RECORD OF OBSERVATIONS, DECISIONS AND ACTIONS that occur outside of strategy meetings or case conference/review - Discussions telephone calls etc</th>
<th>SIGNATURES</th>
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</table>
### 1. Alleged Abuse

**Form/Type of Abuse:**
- Physical [ ]
- Sexual [ ]
- Financial/Material [ ]
- Psychological [ ]
- Institutional [ ]
- Neglect or acts of omission [ ]
- Discriminatory [ ]

**Give Details:**

**2. Were Drugs or Alcohol involved?**
- (Victim) [ ]
- (Perpetrator) [ ]

**Was Domestic Violence a factor in this referral?**
- [ ]

**If a Crime has been committed has this been reported?**
- [ ]

**To who:**

**Details of Safeguarding Concerns and Initial Response –**

Please include a Summary and attach/forward any supporting documentation.

**Supporting Documentation Supplied**
- Yes [ ]
- No [ ]

**3. Any Other Person Dependent on the Alleged Victim (adult/child)?**
- Yes [ ]
- No [ ]

**Give Details:**

**4. Are There Risks to Others eg Children or Other Vulnerable Adults?**

**5. Record Initial Decisions**

**Actions taken to Safeguard Vulnerable Adult:**

**Lead Agency:**

**Safeguarding Manager Accepting Referral:**
- Yes [ ]
- No [ ]

**Name, address and contact number:**

**Strategy meeting arranged for:**
- Date:
- Time:
- Venue:

**People to invite, include full name, work base, telephone number, email address:**

**If not proceeding to Safeguarding Strategy, give reasons and state actions taken:**

**Safeguarding Managers Signature**

**Date:**

**Time:**
Body Map
Please mark on these body maps any bruising/friction marks, burns etc. that the alert may have seen on the body of the Service User giving rise to the alert. In many cases of physical abuse, injuries are often explained as being accidental but if they are evident in soft parts of the body, i.e. under arms, stomach, genitals, or inner thighs, they are less likely to have happened accidentally.
Agenda for Strategy Meeting

1. Circulation of any reports – before meeting so full consideration can be given
2. Introductions/apologies
3. Ground rules
4. Purpose of strategy meeting
5. Previous Minutes where applicable
6. Use format structure of safeguarding form 3
7. Details of incident/disclosure - source of referral, time and date, action to date, contact with the subject and others, any safety or medical interventions – update from previous meeting where applicable
8. Views of the vulnerable adult including consent and limitations on information sharing? – Have they got mental capacity? Is their ability specific to the decision that needs to be made? If unsure what action will need to be taken to establish this?
9. Have the police been contacted for intelligence if not present at the strategy meeting? Are there other agencies we need to contact for information – please list- Consider feedback from other agencies not present?
10. Detail any interim protection plan/action
11. Which process (es) do we need to consider: adult protection, disciplinary, criminal, regulatory, case management etc. Do we need to involve any specialist staff – e.g. communication specialists for a video interview etc
12. Who will take responsibility for each process- log names and responsibilities
13. Who will take responsibility for coordinating the sharing of the information and the decision making about when to progress to case conference?
14. What is the proposed time scale for the investigation
15. In what circumstances might we need to convene a further strategy meeting?
16. Reasons to leave Safeguarding Adult Process (Safeguarding Manager only)
Date of Referral:

Please complete and attached to relevant documentation, then forward to the Safeguarding Adults Office

E-mail:  
Fax:

1. MEETING

Date and time of Strategy Meeting:  
Venue: 
Person Calling Strategy Meeting:

2. INVITED/ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
<th>Position/Agency</th>
<th>Tick if attended</th>
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</thead>
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<tr>
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</tbody>
</table>

3. SUMMARY OF CONCERNS PRESENTED

Nature of Referral:
Initial Responses:
Contact:
Actions to Date:

4. VIEWS OF ALLEGED VICTIM, include, how do they wish incident to be dealt with? 
Do they have any concerns? Are there any limitations placed on sharing information?

5. DOES THE ALLEGED VICTIM HAVE CAPACITY?

Yes: 
If No go to 7

6. MENTAL CAPACITY, is this in all areas?

How was this determined:
To be determined and by whom:
Views of Family or other significant people:
Is an advocate involved:
Is an IMCA involved:

Safeguarding Form 3 – It is Important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
7. BEST INTERESTS

On what basis are you making a best interest decision

If there are no relatives or significant others to consult or the alleged perpetrator is a family member or a significant other has consideration been given to the use of IMCA  Yes:  No:

If No give reasons:

<table>
<thead>
<tr>
<th>Source and detail</th>
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<tbody>
<tr>
<td>LA Social Care:</td>
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<tr>
<td>GP:</td>
</tr>
<tr>
<td>Health:</td>
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<tr>
<td>Police:</td>
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<td>Probation:</td>
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<td>Child Protection:</td>
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<td>Adult Protection Office:</td>
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<tr>
<td>Service Providers:</td>
</tr>
<tr>
<td>Advocacy:</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

8. Information shared from agency checks (on both alleged victim and alleged perpetrator). Identify Source and detail

<table>
<thead>
<tr>
<th>Source and detail</th>
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</thead>
<tbody>
<tr>
<td>LA Social Care:</td>
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<td>GP:</td>
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<tr>
<td>Health:</td>
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<td>Police:</td>
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<td>Probation:</td>
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<td>Child Protection:</td>
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<td>Adult Protection Office:</td>
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<tr>
<td>Service Providers:</td>
</tr>
<tr>
<td>Advocacy:</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

9. Other professionals/agencies involved

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Address</th>
<th>Tel No</th>
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</table>

10. Family members and significant others (including Carers)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Tel No</th>
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</table>

11. IDENTIFICATION OF PRELIMINARY RISKS and Actions taken to reduce potential harm


12. IF DECISION IS NOT TO INVESTIGATE – Give reason


13. WHO IS LEAD AGENCY, named individuals


14. FACTORS TO BE CONSIDERED IN INVESTIGATIONS, Cultural, Religious, Health, Disability, and Communication.


15. FACTORS TO BE CONSIDERED IN INVESTIGATIONS (Need for Special Measures, other)


Safeguarding Form 3 – It is Important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
16. SUMMARY OF INITIAL ACTIONS TAKEN OR ACTIONS FROM LAST MEETING

17. ANY SIGNIFICANT INFORMATION SHARED AND DISCUSSION

18. IF ALLEGATION OCCURRED IN A REGULATED SETTING AND THE STAFF MEMBER CITED, HAS A REFERRAL TO POVA BEEN MADE?

Yes  No

19. IF ALLEGATION OCCURRED IN A REGULATED SETTING HAS OTHER COMMISSIONERS BEEN NOTIFIED

Yes  please note commissioners  No

20. ACTIONS AGREED  BY WHOM  TIMESCALES

21. INTERVIEW STRATEGY, by Whom, method and when

22. STRATEGY / CASE CONFERENCE – arranged for

Date:  Time:
Venue:
People to invite, including full name, worksite, telephone number, email address:
If not proceeding to investigation give reasons and state actions taken:

17. SAFEGUARDING MANAGER

Signature:  Date:

Once the Investigation has been completed a case conference will be required, and should be arranged by the Safeguarding Manager

Safeguarding Form 3 – It is Important to note that should a crime be committed these forms may be used as evidence in a criminal investigation.
Please take care in recording details as this will be used as evidence
| Signature: __________________________ | Agency: ________________________________ |
| Print Name: __________________________ | Address: ________________________________ |
| Tel No: ________________________________ | Position: ________________________________ |
| Email: ________________________________ | |

| Signature: __________________________ | Agency: ________________________________ |
| Print Name: __________________________ | Address: ________________________________ |
| Tel No: ________________________________ | Position: ________________________________ |
| Email: ________________________________ | |

| Signature: __________________________ | Agency: ________________________________ |
| Print Name: __________________________ | Address: ________________________________ |
| Tel No: ________________________________ | Position: ________________________________ |
| Email: ________________________________ | |

| Signature: __________________________ | Agency: ________________________________ |
| Print Name: __________________________ | Address: ________________________________ |
| Tel No: ________________________________ | Position: ________________________________ |
| Email: ________________________________ | |

**Safeguarding Form 3** – It is important to note that should a crime be committed these forms may be used as evidence in a criminal investigation.

Please take care in recording details as this will be used as evidence.
To be completed by the investigator or Safeguarding Manager convening the conference, and sent to: the Safeguarding Adults Office, together with the Convenor's report for the conference.

<table>
<thead>
<tr>
<th>Address</th>
<th>Fax:</th>
<th>E-mail:</th>
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<table>
<thead>
<tr>
<th>Service User</th>
<th>DOB</th>
<th>Care First no.</th>
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<table>
<thead>
<tr>
<th>Care Management category (delete as appropriate)</th>
<th>Older People / Learning Disability / Learning Disability / Physical/Sensory Impairment / Mental Health / Substance Misuse</th>
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<tr>
<th>Social Worker</th>
<th>Team Manager</th>
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<tr>
<th>Name of alleged perpetrator</th>
<th>DOB</th>
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<tr>
<th>Address</th>
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Brief details of reason for convening conference:

<table>
<thead>
<tr>
<th>Strategy meeting held (delete as appropriate)</th>
<th>Y/N</th>
<th>Date</th>
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</table>

Please attach copy of the minutes

If no, please briefly state the reason for this below

If special arrangements are required for the conference (e.g. hearing loop, wheelchair access) please give details below:

Date

Safeguarding Adults - Page 71
Invited by Safeguarding Adults Office:
Investigator should have contacted these professionals to advise of intention to convene conference, and explained the purpose, and the need for their attendance.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Name</th>
<th>Job Title</th>
<th>Address</th>
<th>Tel no</th>
<th>Essential (✓)</th>
<th>*Expecting to attend (✓)</th>
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<tbody>
<tr>
<td>Neighbourhoods and Community Care</td>
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<td>e.g. Social Worker, Team Manager, Contracts Officer</td>
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<td>e.g. G.P., District Nurse, Occupational Therapist</td>
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<td>e.g. Social Worker Psychologist, Psychiatrist, CPN</td>
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* Advised of the purpose of the conference and expecting to attend
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<tr>
<th>Agency</th>
<th>Name</th>
<th>Job Title</th>
<th>Address</th>
<th>Tel no</th>
<th>Essential (✓)</th>
<th>*Expecting to attend (✓)</th>
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<td><strong>Service Providers</strong></td>
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<td>e.g. Home Support,</td>
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<td>Residential Care,</td>
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<td>Day Care</td>
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<td><strong>Probation Service</strong></td>
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<td>Tenancy Support,</td>
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<td>Support/Key Worker,</td>
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<td>Interpreter</td>
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*Advised of the purpose of the conference and expecting to attend

Invited by Investigator:
Please complete this form to ensure that adequate size room is booked.

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<tr>
<th>Role</th>
<th>Name</th>
<th>Address</th>
<th>Expecting to attend (✓)</th>
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<tbody>
<tr>
<td>Service User, Family Members, Advocates</td>
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<tr>
<td>Alleged Perpetrator, Family Members, Advocates</td>
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*Advised of the purpose of the conference and expecting to attend*
AGENDA

Safeguarding Case Conference

1. Circulation of reports
2. Introductions/Apologies
3. Purpose of safeguarding case conference

4. Details of the incident/cause for concern – referral/investigation/outcome; including assessment of capacity
5. Views of vulnerable adult/advocate/carer
6. Chair’s summary – cause for concern/investigation/outcome

7. Background information/wider context
8. Chair’s summary – strengths and difficulties from wider context

9. Risk Analysis
   Conclusions:
   a) On a balance of probabilities, has abuse occurred? If so:
   b) Establish Category of Abuse - refer to criteria
   c) Is there a need for a Protection Plan due to ongoing risk?
   d) Is there a need to make recommendations for the existing care plan?

   NB: When producing a Protection Plan or Care Plan all tasks must be allocated to named individuals within timescales.
   
   e) Identify Contingency Plan and core group membership
   f) Identify how subject/advocate/alleged perpetrator will be notified of outcome if not present
   g) Set Review timescale
Ground rules for conference

NB: Mobile phones, pagers and bleepers must be turned off.

1. Confidentiality
   The content of the meeting is strictly confidential and can only be shared on a need to know basis.

2. Staying for the whole meeting
   It is the intention that the meeting should not last more than 1½ hours. It is important for all conference members to contribute to the development of the protection or action plan. Every effort should be made to stay until the end of the meeting.

3. Responsibility to speak out
   Everyone needs to be open and honest in their contribution to the meeting.

4. Respect for each other’s views
   It is everyone’s responsibility to actively listen to the views of others and not interrupt. Everyone will be given the opportunity to speak.
   Family members will not be subject to direct questioning.

5. Unacceptable behaviour
   Aggressive and/or disruptive language and behaviour will not be tolerated and will result in exclusion from the meeting and possibly from future meetings.

6. Outcomes
   Professionals should record any actions for themselves pending arrival of conference minutes that will be circulated as soon as possible.

7. Minutes
   Ensuring the accuracy of the minutes is everyone’s responsibility. Send any important omissions or corrections to the Chair of the conference within seven days of receipt.
CRITERIA

A vulnerable adult is someone who is or may be in need of health or social 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.

Abuse is a violation of human and civil rights by another person or persons.

Categories of Abuse

Physical abuse occurs when injuries are inflicted or the health/development of the person is severely impaired.

Neglect can be physical e.g. lack of food or drink, and/or emotional e.g. restriction of movement by removal of mobility aids.

Sexual abuse occurs when the person is involved in sexual activity to which they have not consented or, given their level of mental capacity, do not truly comprehend.

Psychological Abuse can involve intimidation, humiliation, threatening behaviour, causing fear.

Financial Abuse is common and takes many forms, the most frequent being when:
- someone who is supposed to be buying basic essentials is not doing so
- a vulnerable person is persuaded to withdraw savings.

Discriminatory Abuse describes repeated, ongoing or widespread discrimination which leads to:
- significant harm
- unequal health or social care
- breaches in civil liberties
- failure to protect.

SAFEGUARDING PLANNING – GOVERNING PRINCIPLES

• A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
• The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
• That individuals must retain the right to make what might be seen as eccentric or unwise decisions;
• Best interests - anything done for or on behalf of people without capacity must be in their best interests; and
• Least restrictive intervention - anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.
CONFIDENTIAL

Safeguarding Adults

Date of Referral:

Please complete and attached to relevant documentation, then forward to the Safeguarding Adults Office

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Fax:</th>
</tr>
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</table>

1. MEETING

Date and time of Meeting:
Person Convening:
Chair and Minute Taker's Details:
Venue:

2. INVITED/ATTENDANCE/APOLOGIES

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Agency</th>
<th>Tick if attended</th>
</tr>
</thead>
</table>

3. SUMMARY OF OUTCOMES WITHIN INVESTIGATION, summaries of reports presented

4. VIEWS OF ALLEGED VULNERABLE ADULT, summary of the contribution made to the conference directly and/or on behalf of the vulnerable adult concerned.

5. VIEWS OF SIGNIFICANT FAMILY MEMBERS or OTHER SIGNIFICANT PEOPLE, Summary of the contribution made to the conference directly and/or on behalf of the vulnerable adult concerned.

6. VIEWS OF ALLEGED PERPETRATOR AND HOW THESES HAVE BEEN REPRESENTED IN CASE CONFERENCE.

7. VIEWS OF ALL ORGANISATIONS AS TO FUTURE RISKS, OVERALL ASSESSMENT OF RISK, IS A MULTI-AGENCY PLAN NEEDED.

8. SERVICES PUT IN PLACE TO PROTECT.

Give details:

Safeguarding Form 4 – It is important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
9. DECISION, Consider balance of probabilities, has abuse been substantiated/not substantiated or inconclusive?

| Substantiated: | ☐ |
| Not substantiated: | ☐ |

10. HAS A CRIME BEEN COMMITTED? Outcome of criminal investigation

| If Yes give Details: |
| If No give police investigation outcomes: |

11. IF A MEMBER OF STAFF HAS BEEN CITED AS ALLEGED PERPETRATOR were they subject to disciplinary procedures?

| Suspended: | ☐ |
| Disciplined give details: |
| Dismissed: | ☐ |
| Other outcomes give details: |

12. IF A MEMBER OF STAFF HAS BEEN CITED AS ALLEGED PERPETRATOR were they referred to POVA/Vetting and Barring Scheme

| Yes: | ☐ |
| What outcome has there been from this action: |
| If no POVA referral made give reasons: |

13. ACTIONS AGREED/SAFEGUARDING PLAN

<table>
<thead>
<tr>
<th>What Action</th>
<th>By Whom</th>
<th>Timescales</th>
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14. REVIEW CONFERENCE DETAILS

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
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<tbody>
<tr>
<td>Venue:</td>
<td></td>
</tr>
<tr>
<td>Convenor:</td>
<td></td>
</tr>
<tr>
<td>Chair:</td>
<td></td>
</tr>
<tr>
<td>If not needed give reasons Why:</td>
<td></td>
</tr>
</tbody>
</table>

15. CASE Closed

<table>
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<tr>
<th>Date:</th>
</tr>
</thead>
</table>

16. SAFEGUARDING MANAGER

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Safeguarding Form 3 – It is important to note that should a crime be committed these forms may be used as evidence in a criminal investigation.

Please take care in recording details as this will be used as evidence.
SIGNATURES OF AGENCY REPRESENTATION PRESENT AT MEETING

Signature: __________________________
Print Name: __________________________
Tel No: __________________________
Email: __________________________
Agency: __________________________
Address: __________________________
Position: __________________________

Signature: __________________________
Print Name: __________________________
Tel No: __________________________
Email: __________________________
Agency: __________________________
Address: __________________________
Position: __________________________

Signature: __________________________
Print Name: __________________________
Tel No: __________________________
Email: __________________________
Agency: __________________________
Address: __________________________
Position: __________________________

Signature: __________________________
Print Name: __________________________
Tel No: __________________________
Email: __________________________
Agency: __________________________
Address: __________________________
Position: __________________________

Signature: __________________________
Print Name: __________________________
Tel No: __________________________
Email: __________________________
Agency: __________________________
Address: __________________________
Position: __________________________

Safeguarding Form 3 – It is Important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
The contents of this report are confidential, for the purpose of the conference only and should not be reproduced, copied or divulged without the consent of the author.

**NB:** This report must be:
- Sent to the Safeguarding Adults Office with the conference notification form.
- Shared with subject/family members/carers/advocate prior to the case conference as appropriate.

### Date of conference: [ ]
### Time: [ ]
### Venue: [ ]

1. **Subject’s details:**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB:</th>
<th>Age:</th>
<th>Sex: M/F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic origin</td>
<td>Religion</td>
<td>Language</td>
<td></td>
</tr>
<tr>
<td>Home address</td>
<td>If living elsewhere, please state:</td>
<td></td>
<td></td>
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</tbody>
</table>

**Attending Case Conference**  YES/NO*  **If not, state reason:**  |

* **NB:** Ensure completion of Subject Consultation form

2. **Other professional/agencies involved:**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
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</tr>
</tbody>
</table>

3. **Author of report:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team/worksite</td>
<td>Telephone number:</td>
</tr>
</tbody>
</table>

*Safeguarding Form 4b* – It is important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
4. **Family composition including significant others eg carers:**

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP TO SUBJECT</th>
<th>DOB</th>
<th>ADDRESS</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

5. **Date of strategy discussion/meeting:**

Factual/chronological account of cause for concern and investigation:

Subject and carers/family members views regarding cause for concern and investigation:

6. **History of health and social care agency involvement:**

---

*Safeguarding Form4b* – It is important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
7. **Assessment of wider context:**

   Agencies prior knowledge/involvement:

   Subject and carers/family members views regarding wider context:

8. **Risk analysis:**

   Identify risk/unmet needs linked to significant harm:

---

**Safeguarding Form 4b** – It is important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
8a. Recommendation to Case Conference:

<table>
<thead>
<tr>
<th>Has abuse been substantiated?</th>
<th>YES/NO</th>
</tr>
</thead>
</table>

If yes, please tick box(s) to indicate category (ies) of abuse:

<table>
<thead>
<tr>
<th>Physical abuse</th>
<th>Sexual abuse</th>
<th>Financial abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect</td>
<td>Psychological abuse</td>
<td>Discriminatory abuse</td>
</tr>
</tbody>
</table>

Then develop a Protection Plan

<table>
<thead>
<tr>
<th>If no, is there a need for a care plan?</th>
<th>YES/NO</th>
</tr>
</thead>
</table>

9. Proposed objectives and plan of action for discussion at the Case Conference:

<table>
<thead>
<tr>
<th>Objectives/actions to reduce risk of harm</th>
<th>Person/agency responsible (include carers/family members)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
<td></td>
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<tr>
<td>4.</td>
<td></td>
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<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
</tbody>
</table>

Investigating Worker’s signature: ............................................. Date: ....................

Safeguarding Manager’s signature: ............................................. Date: .....................

N.B Where a victim’s family/friends are to be invited, ideally, prior to case conference, a discussion will be required to explain process and their involvement.

**Safeguarding Form 4b** – It is Important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
The contents of this report are confidential, for the purpose of the conference only and should not be reproduced, copied or divulged without the consent of the author. NB: This report must be submitted to the safeguarding Adults Office at least 5 days before the conference.

1. Subject’s details:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Home address</th>
</tr>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>If living elsewhere, please state</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

2. Author of report:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Organisation/ Worksite</th>
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<table>
<thead>
<tr>
<th>Telephone number</th>
<th>Fax number</th>
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</table>

<table>
<thead>
<tr>
<th>Email Address</th>
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</table>

3. Relationship to the Service User:

How long have you known the client and in what capacity?

Have you any specialist communication skills to assist the client to be involved in the safeguarding process?

Safeguarding Form 4c – It is important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
4. Background information:

<table>
<thead>
<tr>
<th>Comment on the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The vulnerability of the client:</td>
</tr>
</tbody>
</table>

What risks do you feel the client faces?

Any previous knowledge of abusive situations:

Any other relevant information:

---

Safeguarding Form 4c – It is important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
5. Protection from further abuse:

State what measures can be taken to protect the vulnerable adult from further abuse, specifically covering what you and your organisation can offer:

<table>
<thead>
<tr>
<th>If applicable, state whether you think abuse occurred:</th>
<th>YES/NO</th>
</tr>
</thead>
</table>

If not able at this stage to give an opinion you will need to give your opinion at the end of the conference.

Author’s signature: ................................................ Date: .........................

Safeguarding Form 4c – It is Important to note that should a crime be committed these forms may be used as evidence in a criminal investigation. Please take care in recording details as this will be used as evidence.
To be completed by the subject (assistance to be offered as appropriate)

Name ..........................................................................................................................................

Date of Birth ................................................................................................................................

Address ...........................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................

Date of Conference ....................................................................................................................... 

Do you know why the conference is being held? Yes □ No □

Do you understand the purpose of a Case conference? Yes □ No □

Have you seen the workers report? Yes □ No □

Comments ........................................................................................................................................ 
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................

Has your worker discussed attendance with you? Yes □ No □

Is there anyone that you would like to attend the meeting?

If so, who? ........................................................................................................................................ 

Is there anyone that you think should not be there?

If so, who? ........................................................................................................................................ 

Will you need help to attend the conference? Yes □ No □

Please detail ......................................................................................................................................
If you do not intend to come, it would be helpful if you could indicate why not and any views you have?
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What decisions would you like to see made at the meeting?
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Please write here any other comments you would like to make?
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Signature .................................
Name ..............................................................................................................................................

Date of Birth ....................................................................................................................................

Address ..............................................................................................................................................

Date of Initial Case Conference ........................................................................................................

Date of Review Case Conference ......................................................................................................

Are you aware of the decisions made at the last conference? Yes ☐ No ☐

Did you understand and agree with them? Yes ☐ No ☐

Do you understand the purpose of this meeting? Yes ☐ No ☐

Comments ...........................................................................................................................................

Did you receive the services that you were told you would receive? Yes ☐ No ☐

Comments ...........................................................................................................................................

Has your worker discussed the review of the protection plan with you? Yes ☐ No ☐

Comments ...........................................................................................................................................

Have you seen your worker’s report? Yes ☐ No ☐

Comments ...........................................................................................................................................

SAFEGUARDING Form 4e
Consultation Form for the Subject of a Case Conference Review
If you do not intend to come to the conference please say why?
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What decisions would you like to see made at the meeting?
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Please write here any other comments you would like to make?
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Signature .................................................
**SAFEGUARDING Form 5**
Safeguarding plan – to be completed at the conference by all professionals involved in the Safeguarding plan

**PROTECTION PLAN:**
- Identify objectives
- Identify action/actions to achieve objectives
- Identify person/persons to carry out actions
- Identify timescales in which action to be achieved

<table>
<thead>
<tr>
<th>Objective and Action</th>
<th>Person and Agency Responsible (include carers/family members)</th>
<th>Date Objective to be Achieved by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingency Plan</td>
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</tbody>
</table>
3.13 Reporting Safeguarding Adults concerns to South Yorkshire Police

3.13.1 Types of offence
For the purposes of these policies and procedures, offences will be subdivided into ‘current’, ‘recent’ and ‘historic’.

‘Current’ offences will be taken to mean alleged or suspected offences which have taken place in the 24 hours prior to initial receipt of information about the offence. These offences will require immediate and possibly complex responses including: the need to address service user and possibly staff distress; identification and management of the suspected perpetrator; and identifying and addressing ongoing risk, in addition to preservation of evidence. Urgent contact with the police is required (see process for reporting below). Whilst every effort should be made to engage the adult protection services of the relevant social work team (or the out of hours duty team), urgency means that much of the decision-making for this category of offences may need to be taken by managers of the service. It is therefore crucial that on-site managers liaise very closely with the senior manager on call at every stage of decision-making.

‘Recent’ offences will include those other alleged or suspected offences where there is reliable information about where the offence took place, or some other reason to believe that there is potential for forensic evidence to be preserved and recovered. Modern technology means that forensic evidence such as DNA or fingerprints can in some circumstances be recovered days, weeks or even months after an offence (see guidelines below). In these cases the offence should be reported first to the relevant social work team under the Safeguarding Adults procedures, and contact with the police organised under that umbrella. Action within the service should be limited to preserving evidence and any reasonable action required to verify the information received. If there is reason to believe that the alleged victim or other service users are at risk, then the senior manager on call should make a judgement about what immediate action should be taken to manage that risk without compromising evidence.

‘Historic’ alleged or suspected offences will be those which took place some time in the past but which are only now being disclosed, where individuals have moved on and there is no evidence of current risk. There is unlikely to be any forensic evidence to recover, and people’s memories of events and circumstances are likely to be hazy and imprecise. These offences should be reported using Safeguarding Adults procedures, and normally require no specific action within the service before the strategy meeting.

3.13.2 Process for Reporting to the Police
For ‘current’ offences the service should contact the police immediately.

If a suspect has been apprehended or the identity or whereabouts of a suspect are known, then contact should be via the 999 system and a police response will be despatched immediately.

If the whereabouts of a suspect are not immediately known, contact with the police should be via the [0114] 220 2020 number. An ‘incident’ will be created and you should request the Incident Number from the call handler. The incident will then be passed to duty supervisory officers for assessment and initial contact, in the expectation that, if a serious offence has been committed, contact will be made by the duty Detective.
In the unlikely event that a manager is not immediately available, staff on site must make a judgement about the level of immediate risk to any person at the site, to the loss of evidence and the likely consequences of any delay in contacting the police. If staff do make contact with the police, they must still inform a manager at the earliest possible opportunity.

For all other suspected or alleged offences contact should be made firstly with health or social care services, who will contact the police Public Protection Unit under the Safeguarding Adults procedures and invite them to a strategy meeting at which further action will be discussed and agreed.

3.13.3 Response from the police to reports received via 999
On receiving a 999 report of a serious sexual offence, the police will make a judgement about the urgency of response required in order to secure the safety of the victim and the wider public, and to preserve evidence of the offence.

Where the offence has only just taken place, this response will normally involve immediate attendance at the scene of the alleged offence and advice about further investigation requirements.

The police response will take into account the needs of the victim and their competence to agree to medical examination.
3.14 Relationships with other policies and procedures

These Policy and Procedures must not be viewed in isolation but seen in the wider context of other legislation and policies designed to protect individuals and/or to promote and ensure high standards in care services. Different agencies will have internal procedures, which link to this policy document.

3.14.1 Care Programming Approach

All people receiving a service from secondary adult mental health services are subject to the Care Programming Approach (CPA). This is an overarching system, which incorporates key principles as follows:

- inter-professional working
- assessment of need
- all clients to have a care plan
- this care plan to be reviewed
- care planning to incorporate risk assessment and management plans and crisis plans
- user and carer involvement in all processes
- all clients to have a care co-ordinator.

Service users who have more complex needs will be placed on ‘enhanced’ CPA. Enhanced CPA incorporates mechanisms by which care planning, risk management planning and reviews of care are undertaken through multi-disciplinary review meetings (which also normally involve users and carers).

This can potentially lead to an attitude where the use of Safeguarding Adults procedures is seen as unnecessary, with the CPA review able to take the place of strategy meetings or case conferences. This is a misconception - within CPA, other policies and procedures should be used as and when they are relevant, including Safeguarding Adults. There are many aspects of Safeguarding Adults Procedures that will not be adequately covered by relying on CPA processes alone. Certain aspects of the procedures (such as coordination with the police) may well not ordinarily follow from, and may be missed by, a reliance on CPA processes.

In any case where someone involved with a service user judges that the thresholds for intervention are met, then the Safeguarding Adults procedures should guide action. Guidance should be sought from the local Adult Protection Office or appropriate manager. This should then lead to a decision about how Safeguarding Adults procedures can be followed in a way that complements CPA and does not lead to the repetition of process.

In adult mental health there may be cases where the vulnerable adult is the suspected perpetrator rather than victim of the abuse. As in sections 2.7.4 and 2.10.8, this situation falls within the remit of the procedures, and the local Adult Protection Office should be contacted for guidance on how to proceed. In Safeguarding Adults situations relating to mental health, those involved should be particularly aware of the Mental Health Act 1983. Guardianship provisions (section 7) in particular can be usefully considered in some cases.
3.14.2 Domestic Violence

There is no specific offence of domestic violence and behaviour amounting to domestic violence is covered by a number of statutory provisions.

**Domestic violence** is defined by the Home Office as

‘any violence between current and former partners in an intimate relationship, wherever the violence occurs. The violence may include physical, sexual, emotional and financial abuse.’

Domestic violence occurs across society regardless of age, gender, race, sexuality, wealth and geography.

Some Government agencies and other organisations use slightly different definitions to fit their particular needs. For example, the Association of Chief Police Officers (ACPO) definition includes other family members as well as partners; and the Crown Prosecution Service (CPS) definition includes any criminal offence arising out of physical, sexual, psychological, emotional or financial abuse between current or former partners or family members.

Domestic violence often occurs alongside other issues, such as:

- drugs and alcohol misuse
- deprivation and social exclusion
- homelessness and housing needs
- mental health difficulties
- child abuse and / or animal abuse.

This can make responding appropriately even more complex, and adds to the need for careful assessment to explore the power dynamics involved e.g.

- Who is systematically using domestic violence to control and dominate others within a family or relationship?
- Who is reacting to it, and who is affected by it?

It is important to recognise that vulnerable adults may be the victims of domestic violence or abuse themselves or be affected by it happening within their household. This is likely to have a serious effect on their physical and mental wellbeing. Where vulnerable adults are victims of domestic violence, a referral should be made to the safeguarding adults’ procedures, using the guidance in the flowchart at 2.9.8.

It may be that mainstream police, courts and victim support services or women’s aid outreach services are sufficient to provide a safeguarding plan – however, it may be the case that other services are needed, for example, direct payments advice to replace care provided by an abusive carer.

Any Safeguarding Plan will need to recognise that the violence or threat of violence may continue after a victim has been separated from the abuser. It is important to ensure that all the vulnerable people in this situation have appropriate support to enable them to maintain their personal safety.

**Known perpetrators**

If an adult without mental capacity to make decisions about their safety lives with someone known as a perpetrator of violence and abuse, for example by the police or other agency, a referral to the safeguarding procedures must be made. If a vulnerable adult with capacity lives with a known perpetrator, they should be given information about
the risk and enabled to make a choice about any actions they wish to pursue – including a referral to the Safeguarding Adults procedures.

Responses/services available
Each Council area within South Yorkshire has a Domestic Violence Co-ordinator and multi-agency arrangements and processes to respond to and increase the support available to victims of domestic violence and their dependants [for more details of local sources of support or domestic violence information see Section 4].

Central to this work are the newly developed:
• role of Independent Domestic Violence Advocate [IDVAs]
• Multi Agency Risk Assessment Conferences [MARACs] and the
• specialist domestic violence court programme.
The principle behind these developments is to offer robust multi agency support to those victims of domestic violence considered being at high risk of further violence or abuse.

3.14.3 Self directed budgets and individualised care
Within Health and Social Care provision many individuals will choose to take control of the care package provided by way of Direct Payments and Individualised Budgets. In effect, individuals are responsible for commissioning their own packages of Health and Social Care.

Helping direct scheme users protect themselves from abuse
‘No Secrets’ includes specific instructions concerning the users of direct payments schemes, which recognises the possibility of increased risk of abuse that exists for these people:

‘Anyone who is purchasing his or her own services through the direct payments system and the relatives of such a person should be made aware of the arrangements for the management of adult protection in their area so that they may access help and advice through the appropriate channels. Care managers, who play a role in direct payments, could be asked to help users who are at risk of abuse’. (No Secrets 2000: 7.9).

People employed directly by service users through the direct payments scheme are not subject to regulation by the Commission for Social Care Inspection (CSCI). As a result, the responsibility for monitoring care standards rests with the employer with the support of direct payment scheme staff.

Individuals in receipt of Self-Directed Support do not have access to Criminal Record Bureau, POVA or POCA checks. However, the proposed Vetting and Barring Scheme [see section 3.10] will enable people to check whether someone is a member.

In cases where the care package is provided in full by a CSCI registered agency, it will be the responsibility of the agency involved to undertake the pre-employment checks.

Direct payments recipients should be advised that the contracts they have with their own directly employed staff should include reference to the South Yorkshire Safeguarding Adults Policy and Procedures. Staff directly employed should be made aware of adult protection issues and that any issues of abuse will be reported to Councils with Social Services Responsibilities or to the police.
It is possible for local authorities to place reasonable conditions on any agreement to make direct payments, and conditions might be introduced to protect and safeguard an individual with an identified vulnerability.

Such conditions need to be proportionate to the risk involved and must not defeat the principal purpose of the direct payment, which is to give people more choice and control over their services. However, it should be acknowledged that being in receipt of a Self-Directed Support package is no assurance of a life free from abuse.

This by no means suggests that such individuals should be excluded in any way from the South Yorkshire Policy and Procedure, but that specific mechanisms are identified for this grouping to access the Policy and Procedure on a fair and equitable basis.

3.14.4 Forced Marriage [see also 3.2.11]
Forced marriage is an abuse of human rights. ‘Marriage shall be entered into only with the free and full consent of the intending spouses.’ (Universal Declaration of Human Rights, Article 16 (2))

Forced marriage must be seen in the context of domestic violence and, in the case of vulnerable adults, adult abuse. Policies and best practice used in domestic violence or Safeguarding Adults procedures are the most effective way to tackle forced marriage cases. The aim must always be to put the safety of victims or potential victims first and to focus on prevention, protection and provision.

A clear distinction must be made between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangement remains with the people involved. In forced marriage, one or both spouses do not consent to the marriage and some element of duress is involved. Duress includes both physical and emotional pressure.

Forced marriage is primarily, but not exclusively, an issue of violence against women. Most cases involve young women and girls aged between 13 and 30, although there is evidence to suggest that as many as 15 per cent of victims helped by the Forced Marriage Unit are male.

For vulnerable adults who may have impaired capacity and therefore may not fully understand the nature of marriage, there will be doubts as to their ability to consent to marriage and such situations may be viewed as forced not arranged marriages. A vulnerable adult may agree to a marriage, perhaps encouraged by a well-meaning carer or parent. However, ‘consent’ in the absence of capacity can not be accepted as valid. It should be remembered that a parent or carer cannot give permission for a vulnerable adult to enter into a marriage, whether arranged or not, irrespective of their well-meaning intentions.

The majority of cases of forced marriage reported to date in the UK involve South Asian families. This is partly a reflection of the fact that there is a large, established South Asian population in the UK. However, it is clear that forced marriage is not solely a South Asian problem and there have been cases involving families from East Asia, the Middle East, Europe and Africa. Some forced marriages take place in the UK with no overseas
element, while others involve a partner coming from overseas or a British citizen being sent abroad.

Although there is no specific criminal offence of ‘forcing someone to marry’ within England and Wales, the practice may nevertheless result in criminal offences being committed. Perpetrators – usually parents or family members – could be prosecuted for offences including threatening behaviour, assault, kidnap, abduction, threats to kill, imprisonment and murder. Sexual intercourse without consent is rape, regardless of whether this occurs within the confines of a marriage.

For further information and guidance contact:
The Forced Marriage Unit.
Room G/55. Old Admiralty Building.
Whitehall
SW1A 2PA.
Telephone: 020 7008 0135/0230/8706.
Web: www.fco.gov.uk/forcedmarriage
Email: fmu@fco.gov.uk
APPENDIX 1 RELEVANT NATIONAL BODIES

Public Concern at Work
Tel. 020 7404 6609
16 Baldwins Gardens
London EC1N 7UY
This organisation would be appropriate for staff to contact where they feel inhibited about raising concerns of abuse or malpractice in their working environment.

Elder Abuse Response Line
Tel. 0808 808 8141
(Monday to Friday 10am to 4.30 pm)
Run by Action on Elder Abuse and funded by the Department of Health this confidential helpline gives information to anyone and emotional support for those involved in adult abuse situations.

Ann Craft Trust (formerly NAPSAC)
Tel. 0115 9515400
Centre for Social Work
The University of Nottingham
Nottingham NG7 2RD
A national association working with staff in the interests of people with learning disabilities who may be at risk from abuse. Provides information and advice, peer support networks, publications, training, research and awareness campaigns.

PAVA
(Practitioner Alliance Against the Abuse of Vulnerable Adults)
PO Box 4670
Bournemouth NH6 3BL
Aims to promote the protection of vulnerable adults through networking between professionals.

Counsel and Care for the Elderly
Tel. 020 7485 1566 and 0845 300 7585
Twyman House, 16 Bonny Street
London NW1 9PG
10.00 am to 1.00 pm
Monday to Friday.

VOICE UK
Tel. 01332 869311
The College Business Centre
Uttoxeter New Road
Derby DE22 3WZ
Support and action group for people with learning difficulties who have been abused and for their families.

Action on Elder Abuse
Tel. 020 8765 7000
Astral House
1270 London Road
London SW16 4ER

Change
Minicom: 020 7490 3483
First Floor, 69-85 Old Street, London EC1V 9HY
For people with learning difficulties, especially those who are blind or deaf.

Samaritans
Tel. 020 8692 5228
362 New Cross Road
London SE14 6AG

RESPOND
Tel. 07383 0700
3rd Floor, 24-32 Stephenson Way
London NW1 2HD
Helpline: 0808 808 0700
(1.30 pm to 5pm Mon.- Fri)
A service for people with learning disabilities who have been sexually abused.

National Domestic Violence
Tel. 0345 023 468 (Helpline)

Age Concern
National - 0800 00 99 66

Lesbian and Gay Switchboard
020 7837 7324

Rape & Abuse Line
0808 800 0123
Useful websites

www.annecrafttrust.org
works with staff in the statutory, independent and voluntary sectors in the interests of people with learning disabilities who may be at risk from abuse.

www.bgop.org.uk
'Better Government for Older People'

www.csci.gov.uk
Commission for Social Care Inspection

www.chi.gov.uk
Health Care Commission

www.cjonline.org/citizen/victims
- information about the criminal justice system

www.crimereduction.gov.uk
Home Office Crime Reduction

www.dh.gov.uk
Department of Health

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics

www.elderabuse.org.uk
Action on Elder Abuse

www.homeoffice.gov.uk
The Home Office

www.info.commissioner.gov.uk

www.pavauk.org.uk
Practitioner Alliance against Abuse of Vulnerable Adults

www.pcau.co.uk
Public Concern at Work

www.thehouse.org.uk
A safe house for women with a learning disability

www.refuge.org.uk
Refuge for women and children experiencing domestic violence

www.respond.org.uk
Providing Services to People with a Learning Disability who have experienced sexual abuse.

www.viauk.org
Values into Action.

www.victimsupport.org.uk

www.voiceuk.org.uk
A national charity supporting people with learning disabilities who have experienced crime or abuse.

www.womensaid.org.uk
Women’s Aid – for women and children experiencing domestic violence

www.mencap.org.uk
a learning disability charity working with people with a learning disability and their families and carers
APPENDIX 2: PRESSURE AREA CARE

The information below is taken from work done in Bradford and should be used to guide Safeguarding Adults work in where there are issues of neglect in pressure area care.

Bradford Protocol for Determining Neglect in the Development of a Pressure Ulcer

Issues to Support Decision

Review information already gathered about the patient then consider the pressure ulcer history.

Any grade 3 ulcer (EPUAP - European Pressure Ulcer Advisory Panel Scale) should be considered as possible neglect.

Neglect is described in the Bradford District Adult Protection and Procedures Appendix 3 – Indicators of neglect.

“Persons physical condition/appearance is poor e.g. ulcers, pressure ulcers, soiled or wet clothing”.

If a patient presents with pressure ulcers which are assessed as grade 3 or 4 on the EPUAP Scale, the following assessment should be done by a qualified nurse and the decision reviewed by a second clinical trained person.

Use the following criteria to assess the patient and the history of the development of the pressure ulcer.

To compile the report use the attached format. Review the standard and detail of documentation and evidence of the care regime against the criteria.

The Patient History

• Whether rapid onset and deterioration to a severe ulcer
• Patient Compliance/Behaviour
• Whether extensive damage in a low risk patient

Co-morbidity

• Medical history
• Chronic disease
• Palliative Care
• Mental Health issues

Care Regime

• Poor quality care: standard of assessment and use of relevant policy and procedures to support care and appropriate documentation with a plan of care.
• Whether appropriate equipment has been provided
• Evidence of implementation of the plan of care
• Continence management
• Hygiene
• Deterioration of appearance
• General indicators of care – e.g. clean nails, oral care
• Inappropriate prevention and treatment regimes
• Recurrent pressure ulcers
• Evidence of risk management

Hydration and Nutrition

• Evidence of intake monitoring
• Fluid balance
• Regular weighing
Under/over use of medication
• Note use of sedation if patient is immobile for extended periods
• Is pain assessed and managed

Contributory Circumstances of Pressure Ulcers
• Detailed history of patient journey - e.g. environmental changes
• Change (s) in care setting (s)
• History of falls – has patient been on floor for extended period
• Previous history of pressure ulcers
• Carer involvement
• Health and Social Care involvement

The information should be documented in the recommended format of a report (see attached template), and the case reviewed by a second clinical person to support the decision.

Where appropriate photographic evidence to support the report may be useful. If photographs are taken consent should be documented using the information in the Photography and Video Recording of Patients Policy. However, if there are clear issues of neglect which may lead to a criminal investigation the photography should be done regardless of consent, as described in Bradford District Adult Protection Procedures.

For Guidance on the Prevention and Treatment of Pressure Ulcers Refer to the National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 29 or Organisational Pressure Ulcer Policies.

Preparing a report for Adult Protection.

Name of Patient
DOB
Hospital number / NHS number
Place of current Care:
Previous place of care (if appropriate)
GP or Consultant

Synopsis:
Report prepared by:
At the request of:
Date of report:
Purpose of report:
Main Findings:
Conclusions:

Documentation available at time of reporting:

Patient relevant past history
Should include factual information of pre injury status highlighting medical diagnosis. Include the detailed patient journey and events recording documented dates/times of assessments and action taken. Record risk factors and other details that would impact on the subsequent care and injury.

This section should not contain any opinion or subjective data.
Recent events and description of incident  
This should include detailed recent events that caused the situation to raise concern.  
Raise issues that could contribute to injury or response to patient assessment.  
This section should not contain any opinion or subjective data.

Examination of patient  
Describe patients’ current status include the date of examination. Include photos if possible or details of wound assessment eg size(using grid), colour position etc.

Management  
Report subsequent treatment and care including equipment, specialist care and investigations.

Opinion based on above information  
This section could contain opinion but must be supported by above information or evidence and references (in the form of policy/guidelines, standard practice).

If you have insufficient information to form an opinion record as such.  
Ensure the opinion is objective and can withstand scrutiny and questioning.

Conclusion:  
This must be objective and accurate.

Recommendations:  
Your opinion as to whether this case needs further information or investigation perhaps second opinion second examination.

Authors details:  
Name, Title, Place of work  
Qualifications that make you an expert able to comment on this case.

Signed

Second reviewer:  
Name, Title, Place of work  
Qualifications that make you an expert able to comment on this case.

Conclusions:  
Agree/ disagree add comments

Recommendations:  
As above

Signed

Appendices:  
Eg Photographic image and dates.

This information is confidential.
PROCESS:

Patient identified as possible neglect

Investigation of circumstances (See guidance notes)

Inform Managers

Refer to Adult Protection Officer for organisation

Decision based on review by 2 Health Care Professionals

Home

Hospital

Independent Care Setting

Social Services

Referral to Adult Protection Unit

Commission for Care and Social Inspection

Safety and Remedial Care Plan

Review

Jackie Hansford – Adult Protection Co-ordinator
Kath Vowden – Nurse Consultant, Wound Care

April 2006
Commission for Social Care Inspection

Safeguarding Adults Protocol and Guidance

1.0 Introduction

1.1 This protocol demonstrates CSCI’s commitment to working with other agencies to ensure that people within regulated services are appropriately safeguarded. It replaces the December 2003 NCSC adult protection protocol and has been formally agreed with the Association of Directors of Social Services (ADSS*1) and Association of Chief Police Officers (ACPO). The protocol has the support of the Department of Health. Any regional or local agreements in place must be compatible with this national protocol.

1.2 This protocol needs to be viewed in the context of the government guidance “No Secrets” and more recent good practice guidance issued by the ADSS, ‘Safeguarding Adults: A national framework of standards for good practice and outcomes in adult protection work.’ We have also taken into account the Action on Elder Abuse Adult Protection Data Monitoring Project, which has made specific recommendations about data collection for local councils (references to local councils throughout this protocol are to councils with social services responsibilities).

1.3 CSCI has adopted the “safeguarding adults” terminology throughout the protocol. This is the terminology adopted by the ADSS – the Commission supports the reasoning behind this change, which moves away from locating the cause of abuse with the victim and acknowledges that, whilst the statutory framework differs, safeguarding adults work has equal status with safeguarding children.

1.4 This protocol describes the roles and process for safeguarding adults using the terms used within the ADSS “Safeguarding Standards” as representing the ADSS current view of best practice. Although there may be local variations in how these are described in some councils’ current local procedures the functions and processes

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*1 From 26/03/2007 the ADDS is replaced by the launch of the ADASS (Association of Directors of Adult Social Services)
incorporated in this protocol can generally be applied to CSCI’s engagement in all local safeguarding adults procedures.

1.5 The intended outcome of this protocol is to ensure that our working practices support effective safeguarding and contribute to a reduced risk of abuse for people who use services. This will be achieved by:

   a) Establishing a consistent approach within CSCI to the identification, decision-making, recording and management of safeguarding cases within regulated services.

   b) Promoting a clear understanding of the role of the regulator within the multi-agency safeguarding procedures that is agreed amongst co-signatories to this protocol.

   c) Ensuring that appropriate data is collected about safeguarding adults activity in a way which supports our regulatory role and our performance assessment of local councils.

2.0 Safeguarding Adults: General Principles

2.1 There are a number of general principles that inform our safeguarding adults work:

   a) People who use services have a right to live a life free from abuse, neglect and discrimination.

   b) CSCI acknowledges that, whilst safeguarding is of concern to whole communities, within regulated services the providers of care services and local authority and NHS commissioners and contractors have a key role in Safeguarding Adults. CSCI and the Healthcare Commission will monitor how these roles are fulfilled through our regulatory and performance assessment functions.

   c) CSCI recognises that local councils hold the lead responsibility for establishing and co-ordinating the local interagency framework for safeguarding adults in accordance with the government guidance “No Secrets”. In addition the Director of Adult Social Services is expected to ensure “a clear organisational focus on safeguarding adults in vulnerable situations” (Best Practice Guidance on the Role of the Director of Adult Social Services)

   d) CSCI will work in partnership with other agencies to ensure that concerns or allegations of abuse are appropriately referred to and investigated by the most appropriate agency.
e) CSCI will safeguard the welfare of adults in receipt of regulated services through ensuring compliance with relevant regulations and taking enforcement action where needed.

f) CSCI will ensure that any action we take is objectively assessed, proportionate and reflective of risk presented to people who use services in accordance with our published enforcement policy.

g) Whilst working in partnership with other agencies, CSCI will not suspend its own statutory enforcement responsibilities pending the outcome of another (e.g. criminal) process where to do so would run counter to the safety and well-being of the people who use the service. This is in accordance with lessons highlighted within the ‘Longcare’ inquiry and our statutory duties. In such circumstances we will aim wherever possible to coordinate actions in order to preserve evidence and avoid impeding each other’s investigations or enforcement action.

h) CSCI will seek to continually improve the way in which we work and will engage with partner agencies to consider lessons learnt from individual cases of safeguarding adults and to further develop and enhance the effectiveness of our involvement.

i) CSCI will keep this protocol under review in relation to changing CSCI, government or local interagency policy. We will nominate a safeguarding adults lead amongst our Regional Directors to champion our role in safeguarding and monitor implementation of the protocol.

j) CSCI will use the information gained from both regulatory and performance assessment work to contribute to the overall improvement in the way adults are safeguarded.

3.0 Basis and boundary of CSCI role within Safeguarding Adults procedures

3.1 The Care Standards Act 2000 and the Health and Social Care (Community Health and Standards) Act 2003 place specific responsibilities and duties on CSCI and in working to safeguard adults CSCI must work within that legal framework. CSCI can only use its powers to undertake, and fulfil, its own responsibilities.

3.2 CSCI’s function in response to safeguarding adults concerns is primarily as a regulator, contributing our knowledge of the service, regulations and standards to the multi-agency assessment.
Where a safeguarding alert suggests breaches of regulations or lack of fitness of registered persons, we will consider what regulatory action is needed by the commission and undertake that work in partnership with other agencies.

There are three significant levels of engagement for CSCI in response to a safeguarding alert or referral:

- Where a safeguarding alert or subsequent findings suggest serious risk to a person’s life, health or well-being (these are the Care Standards Act grounds that we consider in relation to urgent cancellation of registration) then we will consider what regulatory action is needed in addition to the investigation/assessment undertaken by partner agencies or the care provider. Whilst in practice we will aim to co-ordinate any regulatory action with the police or commissioners of the service, the need to give primary consideration to our own statutory responsibilities follows the key principle which emerged from the ‘Longcare’ Inquiry (described at para 2.1 g).

- Where the safeguarding adults referral received by the local council suggests breaches of regulations and standards and certain criteria are met in relation to the scale of the abuse, the involvement of registered persons and the regulatory history of the service, CSCI may decide to conduct enquiries and/or initiate a Random Inspection as part of the multi-agency strategy. These criteria are described in more detail in paragraph 8.1 f of this document.

- Where there are no indications of serious risk requiring immediate regulatory action, the outcome of any investigation undertaken by partner agencies or the care provider (shared under the safeguarding adults local information sharing protocol) will inform our decision making about further regulatory action.

3.3 More broadly within regulated services we have duties to inspect to assess compliance with regulations and relevant NMS – We have a duty to report our findings through inspection reports and to take relevant and proportionate action to secure compliance with regulations and conditions of registration.

3.4 In addition to our regulatory function we are responsible for the performance assessment of local councils’ social care services. Each year, the Commission is responsible for producing the performance assessment rating for local councils’ social care. Effective safeguarding is one of the criteria specified as an outcome of effective service delivery. We have included specific data items relating to safeguarding adults within the performance assessment outcomes framework for adult social care 2007.
and this will continue to be an important feature as we develop our performance assessment framework to reflect the outcomes within the government White Paper, "Our Health, Our Care, Our Say". Evidence collected and discussed at routine monitoring meetings between CSCI and the councils may also be included as “admissible evidence” within the performance assessment framework. We will also use information gained through regulatory work to come to judgements about the quality of a council’s adult safeguarding activity.

4.0 Information sharing

4.1 The success of CSCI’s engagement with partner agencies is based on good and timely information sharing. CSCI’s Guidance “Sharing information gained during regulatory activity supports the sharing of information within the context of multi agency procedures for safeguarding adults: the information shared ‘should comprise that which is needed to improve social care services, enable an investigation or to protect people from risk’.”

Please see our published guidance: CSCI information sharing guidance

Wherever possible, the sharing of information with any particular agency should be in accordance with any protocol currently in operation. Where there is no such protocol, CSCI staff can obtain a model from CSCI’s Access to Information Officer.

Any documents prepared by partner agencies that have come into the possession of CSCI as a result of its involvement in safeguarding adults procedures should be stored only for as long as is necessary, and in accordance with the principles set out in CSCI’s Retention and Disposal Schedules. Documents such as minutes of meetings should be retained until there has been a resolution of the case in question. If enforcement action or other legal proceedings involving CSCI have resulted, then in line with other records, documents should be stored for 7 years after the conclusion of the last action.

5.0 Initial response to a notification or alert about a possible safeguarding adult issue

5.1 The ADSS ‘Safeguarding Adults’ standards describe the initial process whereby a partner organisation reports concerns of abuse or neglect as the “alert”. In pursuing our statutory duties the Commission has significant opportunities to identify poor practice and abuse. This may be through the information that is presented to us by others, information that is sought by us as part of our inspection methodologies or through our own direct contact with the service. CSCI will respond to a possible safeguarding adult issue by:
a) CSCI staff who will be receiving concerns about abuse should be familiar with types of abuse (see Appendix A) and consider the good practice advice within the alert standards of the ADSS Safeguarding Adults document http://www.adss.org.uk/publications/guidance/safeguarding.pdf page 31 para 9.3.7)

b) CSCI’s existing concerns, complaints and allegations methodology will assist staff in separating out safeguarding adults issues from other information that can be pursued outside of the safeguarding adults procedures. Where CSCI receives information about a possible Safeguarding Adults issue or concern (including statutory notifications under the service specific regulations) this must be brought to the immediate attention of the lead regulatory inspector for that service or a duty inspector or equivalent depending on the local operational arrangements. The arrangements must be clear in each CSCI local office so that timescales for responding are not compromised.

c) The regulatory inspector will review the information taking into account other known information about the service. This process also applies to safeguarding adults concerns that emerge from CSCI’s own inspection activity. They must then formulate an initial recommendation for IMMEDIATE discussion with a regulation manager to determine what action to take following receipt of this alert.

d) Factors for consideration by the Regulation Manager and regulatory inspector are covered in the accompanying guidance (Guidance : Safeguarding people who use services) The aim is to assess the risk and ensure that appropriate action is prompted without undue delay. Where it is determined that the issue does relate to Safeguarding Adults, CSCI should pass on the “alert” through the referral point agreed within the local procedures (if this has not already occurred). A “Safeguarding adults alert form” has been designed for this purpose. If there is an indication of any criminal activity, there must also be a referral to the local police force; this is imperative, whether or not any urgent or immediate action is contemplated by any of the agencies involved. It is always important to consider the ways in which evidence of any criminal act will be preserved as the response to an incident is co-ordinated, and in some cases, it will be necessary to discuss with a police officer how this will be achieved. This will be particularly important where the criminal act indicated is serious.

5.2 **Timeframe** - the regulatory inspector (or Regulation Manager) dealing with the alert is responsible for ensuring that this occurs the same day as the alert information is received:

a) The local council will provide a clear and accessible referral or signposting point for CSCI and will confirm in each case whether they have decided that the alert is accepted as a referral which will be dealt with within the local procedures. Where the local council has declined to accept it as a referral, the rationale for this is shared with the Commission. Clear agreements about the mechanisms for this will be needed in each local area.
b) Where the source of the information is external, CSCI will send them a letter confirming that we consider this to be an allegation of abuse and that we have referred it to the local council to consider under the local safeguarding procedures of which CSCI is a part.

c) Where the local council’s decision is not to accept the alert as a safeguarding adults referral the local council will inform the original source. The information will be reviewed by a Regulation Manager to determine whether any further action is warranted by CSCI. Further dialogue with the Safeguarding Manager (see below) may be needed to clarify the rationale for the decision.

Note: in this section and elsewhere in this document we have assumed that the local council will act as the “Safeguarding Manager”. The role of the safeguarding manager, as described in the ADSS good practice document, Safeguarding Adults, is to take responsibility for the decision about whether the safeguarding adults procedures are appropriate to address the concern and co-ordinate the safeguarding assessment, plans and reviews. In relation to CSCI regulated services this role is frequently undertaken by someone employed by the local council although it is possible for somebody not employed by the council to fulfil this role.

6.0 Safeguarding assessment strategy (may also be referred to as strategy meetings)

6.1 Where the local council has accepted a safeguarding adults referral the safeguarding manager will develop a multi-agency plan for assessing the risk and addressing any immediate protection needs (the Safeguarding assessment strategy). This could take the form of a telephone discussion rather than a face-to-face meeting – in either case it is convened and chaired under the local safeguarding adults procedures. Key issues for CSCI as a partner agency are as follows:

a) The safeguarding assessment strategy will consider the ongoing risk factors and the implications for the safety and well-being of people who use the service. CSCI has an important information-sharing role in relation to regulated services as described in our information sharing guidance (see link at paragraph 4.1).

b) Where the local council has accepted a safeguarding referral about a regulated service from a source other than CSCI the local council will inform the relevant CSCI local office.

c) There are a few occasions where the issues and concerns are so great that immediate action is required – in these cases there would as a minimum be an immediate strategy discussion with all relevant parties. Where there are indications of possible criminal activity, the police must be directly involved.

d) However in most cases prior to any action being carried out to investigate the concern a Safeguarding Assessment Strategy meeting or discussion
(sometimes referred to as a strategy meeting) is held to agree the investigation strategy, identify who will do what and when and any risk management interventions that may be required.

e) Whilst CSCI should always be made aware of any Safeguarding Adults concern within a regulated service, it is not necessary or appropriate for CSCI to attend all Safeguarding assessment strategies (strategy meetings). However, attendance (or other means of participation such as teleconferences) must occur where one or more of the following criteria are apparent:

   I. One or more registered people are directly implicated
   II. Urgent or complex regulatory action is indicated
   III. If any form of enforcement action has commenced or is under consideration in relation to the service involved.

f) CSCI would generally expect that relevant agencies and other relevant stakeholders such as registered providers and managers, people who use the service and/or their representatives are invited to attend the meeting/participate in the discussion or be otherwise involved in the process. The general assumption is that where registered providers and managers are judged to be fit and not implicated in the alleged abuse then they will be pro-actively involved as partners in tackling the abuse. In some cases, particularly where allegations are made against a registered person, it may not be appropriate for the registered person to be involved - Information supplied by CSCI can assist the Chair in determining whether registered persons are included as a full partner in the strategy discussion.

g) The following must be supplied by CSCI to the chairs of all Safeguarding Assessment strategy meetings convened in relation to regulated services whether CSCI staff will be attending or not:

   I. Name, address, telephone number of service
   II. Name of registered provider/company (if applicable)
   III. Name of registered manager (if applicable)
   IV. Type of registration
   V. No. of places registered (if applicable)
   VI. Category(ies) of registration, with number of places
   VII. Conditions of registration
   VIII. Enforcement action underway or pending
   IX. Complaints investigations underway or pending
   X. Most recent inspection report
   XI. Quality rating (when implemented)
   XII. Any direct information relating to the allegation obtained through our inspection process

6.2 A form has been developed for this purpose – Safeguarding Adults Assessment Strategy Meeting Information form.

6.3 Whether or not CSCI staff attend the Safeguarding Assessment strategy meeting, CSCI must be supplied with copies of the minutes and agreed strategies
formally by the chair of the meeting. Records relating to the safeguarding proceedings may be subject to Freedom of information act requests; comments or actions attributed to CSCI should be checked for accuracy. The regulatory inspector is responsible for ensuring appropriate communication liaison is established. Where the inspector is concerned that the proposed response will not effectively safeguard people using the service this should be discussed with the Regulation Manager.

7.0 What should be clarified during a strategy meeting?
7.1 CSCI staff must not chair or function as minute takers for Safeguarding Assessment strategy meetings.

7.2 Where CSCI attends a Safeguarding Assessment strategy meeting it is essential that full notes of discussions and agreements are made which should be checked against the draft minutes of the meeting and amendments proposed where necessary. The aim is to ensure that the final record of the meeting reflects the input and agreed actions of all parties. Information shared at a strategy meeting should only be used for the purpose of safeguarding adults.

7.3 The core business of a strategy meeting includes:

i) Assessing current information regarding risk to people using the service
ii) Developing an Interim safeguarding plan and support for alleged victims whilst risk assessment/investigation takes place
iii) Establishing who will undertake the risk assessment/investigation and how other activities are co-ordinated with that
iv) Agreeing communication strategy between the relevant agencies during the assessment/investigation (including involvement and communication with the registered provider)
  v) Agreeing support for alleged victims, relevant family/carers, staff who are whistle blowers
  vi) Agreeing the wider communication strategy where required, including considering whether a media or public relations strategy is needed.

8.0 Safeguarding assessment – Possible investigation strategies

8.1 There are a range of options for investigating Safeguarding Adults referrals and the appropriateness will be dependent on the circumstances of each case. Possible strategies may include one or a combination of some of the following:

a) Police investigation – Into allegations which relate to possible criminal activity and where a criminal prosecution may be indicated – Where this is the prime investigation strategy other agencies must ensure that their input or action does not adversely impact on the integrity of the investigation.
b) Social Services lead investigation – Local social services are the lead authority for co-ordinating Safeguarding Adults procedures but may also be the commissioners of care. Examples of where social services should conduct investigations include where the concerns relate to compliance with service agreements, individual care contracts or other contractual expectations – Their input is also indicated where the care needs of individual service users may have been compromised and that a review or reassessment is necessary. Where one person using the service has abused another an assessment of that person’s care may be needed. People who purchase their own care within regulated services are included within the remit of the safeguarding procedures.

Where the service includes people placed out of area the host authority will normally manage the safeguarding procedures (in accordance with the ADSS cross boundary protocol)

c) Healthcare organisations - In certain circumstances healthcare organisations may complete an investigation into safeguarding issues. This should be part of the local multi-agency procedures so that the local council can co-ordinate and quality assure the investigation strategy and outcome.

If local councils are concerned about the quality or robustness of work undertaken by healthcare organisations either to investigate or to address safeguarding concerns they should raise this with the appropriate executive lead (for NHS trusts) or responsible individual (for independent healthcare providers). If the local council’s concerns are not resolved, they should inform the strategic health authority (for NHS patients only) and send a copy of their concerns to the Healthcare Commission’s regional team; for independent healthcare patients they should directly inform the Healthcare Commission’s regional team, who will consider what further action might be needed.

d) Healthcare Commission – The Healthcare Commission may complete an investigation into safeguarding issues that affect NHS patients in accordance with their published criteria:

Healthcare Commission NHS investigations criteria

The Healthcare Commission may also conduct enquiries or initiate an inspection where the allegation suggests breaches of regulations and standards and take appropriate regulatory action.

e) Registered Provider / Manager – The relevant agencies will decide at the beginning of the strategy process whether it would be
appropriate for the registered provider or manager to conduct an investigation. Factors that should be considered include:

I. Current CSCI service quality rating including judgements about the management of the service
II. Previous history of effective concerns & complaint investigation
III. Implications for the registered person in terms of the focus of the allegation, investigation required and possible outcome
IV. Agreement of all agencies

Where it is agreed that the registered provider/manager should investigate the concern this will often be in partnership with other agencies. For example an investigation of a concern relating to the conduct of staff employed within the service and where the findings may lead to disciplinary action by the employer.

f) Where the allegation suggests breaches of regulations and standards, CSCI may conduct enquiries using our existing methodologies and/or initiate a Random Inspection and take appropriate regulatory action. (A ‘random inspection’ in this context is an unannounced inspection focused on the regulatory issues within the safeguarding referral). Some illustrative examples are included as Appendix B.

The following criteria will be used to inform the decision:

I. Allegations directly implicate one or more registered person
II. Current service quality rating and rationale, plus any links to risk for service users accommodated
III. Enforcement action has commenced in relation to the conduct of this service or one or more registered person in relation to risk for people who use the service
IV. The allegations if proven, indicate that urgent or immediate regulatory action may be necessary
V. Where the allegations relate to complex and serious conduct issues particularly those indicating possible institutional or cultural abusive or neglectful practice

N.B. Where the above criteria do not apply and the allegation is investigated by another person/agency the Commission will consider what regulatory activity (if any) needs to follow once the investigation has been concluded and the outcome shared with CSCI (under the local Safeguarding adults info sharing protocol).

8.2 If concurrent investigations (from more than one agency) are taking place any reports must be provided to the Safeguarding Manager for the case. The safety and welfare of the people who use the service is
paramount. Any decision by CSCI to take regulatory action - as a result of an inspection or other information received - should not be unnecessarily delayed; however the safeguarding manager should be informed of any such decision and this should be discussed with the organisation leading the safeguarding assessment. For example, if this is the police it is important that any actions by CSCI do not adversely affect the gathering of evidence as part of a criminal investigation. The timing of feedback from regulatory action must be agreed with the relevant Regulation Manager or duty Regulation Manager in line with CSCI media protocol, but all efforts should be made for this to be coordinated with the actions of partner agencies.

8.3 Regulation Managers must ensure that workload management strategies ensure that all fieldwork inspections relating to Safeguarding Adults issues are completed as a matter of priority and in accordance with current methodologies.

9.0 The safeguarding plan

9.1 Agencies who have been involved in the investigation/safeguarding assessment will share information in accordance with any information sharing protocols in place to arrive at a conclusion about whether abuse took place. The outcome of the safeguarding assessment (including investigation reports where appropriate) must be shared with CSCI where it relates to a regulated service. Where the abuse is deemed to have taken place a multi-agency meeting will typically consider the current risk, consider what actions need to take place to prevent a repeat of the abuse by an individual or organisation and consider what further actions are necessary to safeguard the person (or people) using the service. The person (or people) using the service should be involved where they have the capacity to do so and to the extent to which they wish to be involved.

The principles and provisions of the Mental Capacity Act (to be implemented April 2007) will need to be considered where appropriate. For example, Lasting Power of Attorneys or Court Appointed Deputies with powers to make welfare decisions may need to be involved in the safeguarding plan and local councils will have the discretion to extend the services of their Independent Mental Capacity Advocacy schemes to safeguarding adults cases.

9.2 Whilst other agencies will have greater influence over the safeguarding plan for the individual person using the service, CSCI within its regulatory role will have an influence in ensuring adherence to parts of the safeguarding plan that relate to service compliance with regulations and standards. Where we have already undertaken some inspection activity as part of the multi-agency response to the concerns, we will have considered whether any enforcement action was needed based on our findings. Our enforcement policy includes an overview of our enforcement powers and is available at the following link:
CSCI enforcement policy

Where we have not yet undertaken any regulatory activity connected with the initial alert and the outcome of the investigation by partner agencies is substantiated and indicates breaches of regulations and standards we will evaluate this information and consider whether any further regulatory activity is required. CSCI management review meetings may be convened where appropriate. Any decisions to take such action will be communicated to the Safeguarding Manager.

9.3 One of the potential recommendations that may emerge from a safeguarding plan meeting to reduce the risk of recurrence of the abuse is to refer the perpetrator to the Protection of Vulnerable Adults (POVA) list (or it successor, the new vetting and barring scheme) and/or the relevant professional body such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and General Social Care Council (GSCC). Whilst the responsibility for making the referral usually rests with the employer, CSCI does have the power to make such referrals where the registered person is the subject of the referral or where they have failed to make the appropriate referral. Where a registered provider fails to fulfil their statutory duty to make referrals to the POVA list this may call into question their fitness.

10.0 Collection of data about the level of Safeguarding Adults activity
10.1 CSCI data collection will be incorporated in the supporting methodology that underpins this protocol and will include the following elements:

- Information to support our engagement in local safeguarding procedures within the terms of this protocol
- Information that will contribute to national reporting
- Information that can assist with performance assessment of how well councils are fulfilling responsibilities for safeguarding adults

It is important to note that CSCI’s data collection in this area is not a substitute for local councils’ own data collection and monitoring in order to quality assure and evidence the effectiveness of the local safeguarding procedures which they have established. The Action on Elder Abuse Adult Protection Data monitoring report contained specific recommendations for local councils which were accepted in principle by the Department of Health. Action on Elder Abuse Data monitoring Report
11.0 Safeguarding adults partnership boards (also known as Adult Protection Committees)

11.1 CSCI will continue its involvement in safeguarding adults partnership boards where these are in place. These are strategic bodies comprising the key partners that have a role in ensuring that the safeguarding adults procedures are effectively implemented within the local area.

11.2 CSCI will participate as active members within these boards - for example, in clarifying the role of the regulator, sharing relevant information and promoting joint working with relevant agencies. However CSCI do not have a decision-making role in relation to the local councils’ implementing their lead responsibility for establishing and co-ordinating the multi-agency procedures. This is because we need to assess councils’ performance of their safeguarding adults responsibilities as part of our wider performance assessment role.

11.3 It will normally be Regulation Managers rather than Business Relationship Managers (BRMs) who are CSCI representatives within the boards as it is the BRMs that are the regular interface with councils in the performance assessment role. In circumstances where the Regulation Manager needs to give feedback to the BRM about an aspect where a council is failing to fulfil its safeguarding responsibilities then this will be shared with the chair of the safeguarding board and any judgement that stemmed from this would be agreed as part of the evidence set.

12.0 Serious case reviews

12.1 Councils are urged within the ADSS good practice standards (Safeguarding Adults) to develop an agreed multi-agency protocol for the commissioning and undertaking of a safeguarding adults serious case review. Whilst there is no statutory requirement for CSCI to be notified of serious case reviews (unlike for children’s serious case reviews) it is accepted as part of this agreed protocol that CSCI be formally made aware of both the instigation of any adults serious case review and its outcome. These are important in contributing to our judgements about how councils serve their population and subsequently put into practice any lessons learned. It is also an important component of developing an overall picture of the state of social care.

12.2 Where the serious case review relates to a regulated service and CSCI has been part of the multi-agency response, we may be a participant in the serious case review.
13.0 Quality assurance

13.1 It is important that staff operating within this protocol are fully aware of what is expected within their role. This section aims to highlight some of the key responsibilities arising from the protocol but excluding the wider range of regulatory activity that contributes to safeguarding that will be part of the day to day role of CSCI staff e.g. inspection against regulations and standards (such as standards relating to complaints and “protection”). Similarly our published enforcement guidance already specifies the expectations within various CSCI roles in relation to enforcement activity.

In relation to this protocol:

13.2 All CSCI staff are responsible for:

• Ensuring that they respond, sensitively and professionally to contacts with us which are reporting alleged abuse
• Ensuring that they are familiar with types of abuse as described in ‘No Secrets’

13.3 Business Services staff are responsible for:

• Providing necessary administrative support to ensure that the CSCI procedures that underpin this protocol are undertaken within the timescales
• Maintaining an overview of the various process steps from receiving an alert onwards including the ICT processes involved

13.4 Inspectors are responsible for:

• Ensuring that they are familiar with the local safeguarding adults procedures
• Reviewing information received which includes a safeguarding adults concern in the light of other information that we hold and making a recommendation about further action (e.g. to supply as an alert to the local council)
• Ensuring that safeguarding alerts are passed on to the nominated officer within the local council and the police (where appropriate) on the same day as the alert information is received
• Ensuring that the relevant information listed in the protocol is supplied to inform the safeguarding assessment strategy (strategy meetings)
• Following up on the progress of safeguarding referrals and ensuring that we receive information about the outcome
• Planning and undertaking any regulatory activity needed in relation to the safeguarding alert whether as part of the multi –agency procedures or following their conclusion
13.5 Regulation Managers are responsible for:

- Ensuring that they are familiar with the local safeguarding adults procedures
- Ensuring that new staff are made aware of the CSCI national protocol and of the local multi-agency procedures (including the referral route)
- Formulating a decision about what action should follow receipt of a safeguarding adults concern including an assessment of immediate risk
- Reviewing any decision by the local council not to accept an alert from CSCI as a referral under the local procedures and considering whether any further action should follow
- Ensuring that within workload management strategies all fieldwork inspections relating to safeguarding adults issues are completed as a matter of priority
- Representing CSCI at Safeguarding Adults Partnership boards (Adult Protection Committees)
- Providing managerial oversight, support and guidance to inspectors in relation to safeguarding adults activity

13.6 Business Relationship Managers are responsible for:

- Ensuring that judgements about effective safeguarding by local councils take into account available relevant information from regulated services, CSCI engagement with local Safeguarding Adults Partnership Boards and any serious case reviews.
- Providing managerial oversight, support and guidance to Regulation Managers in relation to safeguarding adults activity

13.7 Regional Director safeguarding national lead is responsible for:

- identifying operational difficulties
- ensuring regional consistency of application
- monitoring and reviewing the operation of the protocol and its impact on regulation and inspection activity
APPENDIX 4: PROTOCOL WITH HM CORONERS’ OFFICES

Background

The four Safeguarding Adults Boards in South Yorkshire are responsible for ensuring that effective multi-agency processes are in place to protect vulnerable adults.

On occasions HM Coroner may have concerns about events leading to the death of a vulnerable adult. These are likely to fall within the following categories:

1. Where there is an obvious and serious failing by one or more agencies.

2. Where there are no obvious failings, but the actions taken by agencies require further exploration/explanation.

3. Where a death has occurred and there are concerns about others in the same household or other setting.

4. Deaths that fall outside the requirement to hold an inquest but where follow up enquiries/actions are identified by the Coroner or his officers.

Procedure

In any of the above circumstances the Safeguarding Adults Co-ordinator, or the chair of the Safeguarding Adults Board will provide a point of contact for initial discussions.

Where the death falls into category 1 above, then those contacted will take steps to alert the agency concerned and ensure that records and other evidence are preserved. HM Coroner will be provided with contact details to follow up this immediate action with formal notification of an interest to the head of the agency in question.

Where the death falls into categories 2, 3, or 4 above, enquiries will be made and HM Coroner will be advised of the outcome, in the light of which further consideration of the circumstances will take place.

Within category 3 above, the Safeguarding Adults Co-ordinator will also consider whether risks to other vulnerable people warrant the use of the South Yorkshire Adult Protection Procedures.

Where police enquiries have been requested by the Coroner, the police officer in the case will be advised to make contact with the relevant Safeguarding Adults Co-ordinator or Safeguarding Adults Board Chair and discuss the most effective way of accessing the required information.
1 Introduction
1.1 The purpose of this document is:
• To support the view that the public interest is best served by the presence of an effective serious case review process
• To provide guidance to Safeguarding Adults Boards (SGABs)
• To facilitate a consistent approach to the process and practice in undertaking a serious case review
• To acknowledge that there is no statutory requirement for agencies to co-operate with such reviews, however, voluntary involvement does lead to good practice development

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

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

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

2 Relevant Standards

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

There is a clear process for commissioning and carrying out of a serious case review by the partnership

3 Purpose
The purpose of having a case review is not to reinvestigate nor to apportion blame, It is:

3.1 to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults

3.2 to review the effectiveness of procedures (Both multi-agency and those of individual organisations)
3.3 to inform and improve local inter-agency practice

3.4 to improve practice by acting on learning (developing best practice)

3.5 to prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

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

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

### 4 Criteria for Serious Case Review

The SGAB has the lead responsibility for conducting a serious case review.

A serious case review should be considered when:

4.1 A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death. In such circumstances the SGAB should always conduct a review into the involvement of agencies and professionals associated with the vulnerable adult.

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

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

### 5 Process for commissioning and carrying out of a serious case review

5.1 The SGAB will be the only body which commissions any serious case reviews. The Board will publicise both the process under which applications for reviews may be made and the terms of reference for each serious case review.
5.2 There must also be mechanisms for the consideration of requests from the Coroner, MPs, Elected Members and other interested parties.

5.3 Applications must attract the support of the quorum of the Board be made in writing.
5.4 In the event of an application being turned down, the reasons need to be recorded in writing and shared with the applicant.

6 Initiating a serious case review

The case for review will be passed to the Chair of the SGAB to initiate a discussion / decision by the quorate Board. If it is agreed, a multi agency Serious Case Review Panel will be set up:

6.1 The SGAB will be responsible for the appointment of an Independent Panel Chair.
6.2 The SGAB will ensure the Serious Case Review Panel Chair receives adequate support.

6.3 The Chair of the Panel will be responsible for establishing individual terms of reference and setting time scales for the review in agreement with the SGAB. They will also be responsible for ensuring administrative arrangements are completed and that the review process is conducted according to the terms of reference.

6.4 The Chair of the SGAB will then write to the Chief Officers of all the agencies involved for nominations to the Serious Case Review Panel.

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

6.6 Each agency will nominate a representative who has appropriate experience.

6.7 CSCI have asked that they be informed of any Serious Case Review taking place.

7 Conduct of Serious Case Review:

7.1 Initial Meeting
This will agree;
• the terms of reference
• the “evidence” required from each participant
• the support and other resources needed (any perceived deficits to be referred to Chair of SGAB)
• the time scales within which the review process should be completed
• dates, times and venues of meetings
• the nature and extent of legal advice required, in particular: Data Protection, Freedom of Information and Human Rights Act

7.2 Serious Care Review-receipt of evidence
This stage of the meeting is a formal “information sharing” session where
agencies will be encouraged to query and comment on the reports presented. Each agency involved will be asked to:
- Present and examine the chronology of events, highlighting any discrepancies
- Present a comprehensive report of the actions by their agencies
- Ensure any other management reports and other relevant information are made available

7.3 Serious Care Review-discussion of evidence/ “adjudication”
This stage is where the assessment of alternative courses of action takes place.
The review panel will:
- Cross-reference all agency management reports and reports commissioned from any other source
- Examine and identify relevant action points
- Form a view on practice and procedural issues
- Agree the key points to be included in the report and the proposals for action

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

The Chair of the review panel should report back to the SGAB and a decision made as to whether the serious case review process should be suspended pending the outcome of such notification.

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

7.6 Acting on the recommendations of the Serious Case Review
On completion, the Overview Report will be presented to the SGAB, which will:
- Ensure contributing agencies are satisfied that their information is fully and fairly represented in the Overview Report
- Ensure that the Overview Report contains an Executive Summary that can be made public
- Translate recommendations from the overview into an action plan, which should be endorsed at senior level by each agency

The action plan will indicate:
- Responsibilities for various actions
- Time-scales for completion of actions
- The intended outcome of the various actions and recommendations
- Mechanisms for monitoring and reviewing intended improvements in practice and/or systems
7.7 Recommendations
The SGAB will ensure that all recommendations are actioned and will request updates from agencies

The action plan will remain on the SGAB Agenda until such time that all recommendations have been implemented

8 Annual Report
• All Serious Case Reviews conducted within the year should be referenced within the annual report along with relevant service improvements

APPENDIX Other Considerations for a Serious Case Review
• There will be a need to address the budgetary requirements for undertaking a Serious Case Review
• Time scales for the completion of a Serious Case Review will need to be put in place to ensure that the process takes place within a timely and specific framework. By comparison, a Domestic Violence Homicide Review aims to be completed within three months
• SGAB are advised to liaise with their local Coroners Office to ensure that the arrangements for undertaking a Serious Case Review are acceptable
• Due regard for criminal/civil process should be observed at all times
• Arrangements to obtain or secure records through statutory agencies should be utilised whenever appropriate, e.g. Police, CSCI
• Circumstances may arise whereby it is appropriate to consult or involve a victim of abuse or a relative. This involvement should be carefully considered
• The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the ‘right to know’, came into force in January 2005
• There are ‘absolute’ and ‘qualified’ exemptions under the Act. Where information falls under ‘absolute exemption’, the harm to the public interest that would result from its disclosure is already established
• If a public authority believes that the information is covered by a ‘qualified exemption’ or ‘exception’ it must apply the ‘public interest test’
• The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it
• The Data Protection Act 1998
• Children Act 1989 – updated 2004
• There may be need for the completion and implementation of media and communication strategies

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Anne Graves - Doncaster SSD
Joanne Purdie - Leeds SSD
APPENDIX 6: INDEPENDENT MENTAL CAPACITY ADVOCACY

ADASS - PRACTICE GUIDANCE

CRITERIA FOR THE USE OF IMCAs IN SAFEGUARDING ADULTS CASES

Introduction

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

The Act sets out core principles and methods for making decisions and carrying out actions in relation to personal welfare, healthcare and financial matters affecting people who may lack capacity to make specific decisions about these issues for themselves.

The Act introduces several new roles, bodies and powers, all of which support the Act’s provisions. One of these is the Act is the Independent Mental Capacity Advocacy (IMCA) Service, which introduces the role of the Independent Mental Capacity Advocate (IMCA).

Independent Mental Capacity Advocate (IMCA) Service

The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack capacity, make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working to determine their best interests.

More recently the DoH extended the Act through Regulations to cover two additional circumstances a) where a safeguarding adults allegation has been made and b) in care reviews.

This ADASS Practice Guidance focuses on the first circumstance and provides guidance on which eligible individuals under safeguarding adults measures would benefit from having the involvement of an IMCA, ensuring that the available resources are targeted to those in most need.

This ADASS Practice Guidance should be read in conjunction with your own Local Authority’s Safeguarding Adults Multi-Agency Policy and Procedures.

Who is Eligible?

In relation to safeguarding adults cases, the Regulations specify that Local Authorities and the NHS have powers to instruct an IMCA if the following requirements are met:
• Where safeguarding measures are being put in place in relation to the protection of vulnerable adults from abuse; and
• Where the person lacks capacity

The Local Authority or NHS body may instruct an IMCA to represent the person concerned if it is satisfied that it would be of benefit for the person to do so.

In safeguarding adults cases only, access to IMCAs is **not restricted** to people who have no one else to support or represent them. Therefore, people who lack capacity who have family and friends can still have an IMCA to support them through the safeguarding process.

The regulations equally apply to a person:

• Who may have been abused,
• Who has been neglected and
• Who is alleged to be the abuser

Where the qualifying criteria are met, it would be unlawful for the Local Authority or the NHS not to consider the exercise of their power to instruct an IMCA for safeguarding adults cases.

### Assessing Capacity in relation to Safeguarding Adults Issues

Someone is said to lack capacity if they are unable to make a particular decision at a specific time. This inability must be caused by an impediment or disturbance of the mind or brain, whether temporary or permanent.

In order to make a decision, the person needs to be able to:

• Absorb basic information about the pros and cons of an issue
• Retain the information for long enough to process it
• Weigh up the pros and cons against their own value system and arrive at a decision
• Communicate that decision

The Mental Capacity Act Code of Practice includes a two-stage test of capacity and to be eligible for the IMCA service a person must lack capacity in relation to a specific issue or decision in question.

*For example:*

*A person may not be able to absorb and weigh up the pros and cons of continuing to live with an abusive family member*

### At what point in the process should an IMCA become involved?

Consideration should be given as to the most appropriate time to instruct an IMCA in safeguarding adults cases. This will be dependent on the decisions to be made and the risks to those involved. In some cases it will be appropriate to involve an IMCA at the Strategy Discussion/Meeting stage. This would need to happen for cases where the wishes/decisions made by the individual would have a significant impact on the
investigative process or where immediate actions need to be taken to safeguard the individual prior to further investigation taking place.

In other cases, it may be more appropriate for an IMCA to become involved at the case conference/safeguarding planning stage so that they can provide input into the safeguarding plan. This would be more appropriate in cases where decisions need to be made as a result of findings of the investigation.

Where an IMCA has been involved at any stage of the safeguarding process, they should be invited to attend Safeguarding Adults Meetings, as appropriate, including any subsequent reviews. The involvement of the IMCA should be reviewed once the specific decisions that prompted the referral have been resolved.

In some situations, a case may start out as a safeguarding adults case, where consideration is given whether or not to involve an IMCA under the set criteria – but this subsequently becomes a case where the allegations or evidence give rise to the question of whether the person should be moved in their best interests. The case then becomes one where an IMCA must be involved if there is no one else appropriate to support and represent the person in this decision.

In those cases involving Lasting Powers of Attorney, where there is reasonable belief that the person holding the LPA is not acting in the best interests of the person lacking capacity, an application should be made to the Court of Protection for either a best interest decision or to displace the LPA before an IMCA is considered.

**What are the criteria for referring someone to the IMCA Service?**

The IMCA Service is a limited resource and it is important that the use of IMCAS focuses on cases where other arrangements are not robust enough to support the necessary decision-making for the individual. An external (IMCA) opinion will give a more defensible and more person-centred outcome.

In order to ensure that the IMCA Service is targeted to those in most need it is recommended that, in relation to safeguarding adults, referrals to the IMCA Service are made in cases where one of the following applies:

**For someone who may have been abused or neglected**

- Where there is a serious exposure to risk
  - Risk of death
  - Risk of serious physical injury or illness
  - Risk of serious deterioration in physical or mental health
  - Risk of serious emotional distress
- Where a life-changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person’s best interests at heart
- Where there is a conflict of views between the decision makers regarding the best interests of the person
For someone who is alleged to be the abuser

- Where a life-changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person’s best interests at heart
- Where there is a conflict of views between the decision makers regarding the best interests of the person

Traditional Advocacy Services

When the person is already supported by an approved advocacy service, there should be no need to involve the IMCA Service. In many cases, a person will be best served having an ‘ordinary’ advocate who can cover all issues and not have strict time limits on their involvement.

This Policy Statement is to be reviewed in April 2008 when the IMCA Service has been operational for 12 months
1.0 **Principles**

1.1 In jointly commissioning the Independent Mental Capacity Advocacy (IMCA) Service, the four Local Authorities of Barnsley MBC, Doncaster MBC, Rotherham MBC and Sheffield City Council agree with the guidance as set out in Part 10 of the Mental Capacity Act 2005 Code of Practice.

1.2 Furthermore, the four authorities are jointly committed to supporting the service provider in delivering a service across South Yorkshire based on the Commissioning guidance and recommendations as set out by Turning Point and University of Cambridge.

1.3 The IMCA service is based on a decision focused approach to advocacy to protect people lacking decision making capacity. It is not the purpose of the IMCA service to provide assistance when decisions are finely balanced or complicated, rather than because a person lacked decision making capacity.

2.0 **Criteria and Call off Arrangements**

2.1 Each LA must agree with the criteria as set out in the commissioning guidance by Turning Point. Further extension to the role of IMCA’s were provided by Regulations SI 2006/2883.

2.2 It is understood that the priority of referrals will be primarily associated with statutory duties and powers, i.e.: Serious Medical Treatment or Changes of Accommodation.

2.3 Given the initial allocations of resources it is unlikely to be able to establish a definitive list of exclusion within the first year of operation.

2.4 With this in mind, the Commissioning Group agreed that the extension of the IMCA role should be accepted, in line with recommendations from Policy Statement from Association of Directors of Social Services, and be extended to cover Care Reviews and Adult Protection Cases. (see ref 5)

2.5 Arrangements for provision under 2.4 will be initially for 12 months, with review on an annual basis by the strategic group, or by further statutory guidance.

2.6 Each LA, via their Local Implementation Network should ensure that clear policy and procedures are made available to Decision – Makers. This should outline the criteria to be applied when deciding for each eligible individual.

2.7 The South Yorkshire IMCA Strategic Group have agreed that the ordinary residency rules apply and should an eligible individual be temporary placed in another location outside South Yorkshire (eg: Hospital), speaking up would be the nominated IMCA’s provider. However, subject to geographical practicalities,
negotiations may take place between speaking up and local providers to ensure clients are not disadvantaged. For individuals who are temporarily relocated to South Yorkshire, then the South Yorkshire IMCA service provider would pick up and subject to Commissioning Guidance, the cost would be negotiated with the individual’s originating authority.

2.8 For eligible individuals who are temporarily relocated to another South Yorkshire Authority, then Speaking Up would be IMCA service of choice as they provide a South Yorkshire wide service. However, the cost of providing the IMCA service would be charged to the individual’s LA where they ordinarily reside.

2.9 In order to ensure that eligible individuals are offered timely intervention, referrals should be made directly to “Speaking Up”. Inappropriate referrals should be recorded for data purposes and re-directed back to originating source.

2.10 Spot purchasing outside of main contract with “Speaking Up” would be charged at a rate of £25 per hour

3.0 **Maintaining Performance and Contract Compliance**

3.1 A Contracting Officer, employed by the 4 LA’s and hosted by Rotherham MBC will hold quarterly face to face meetings with IMCA Service Provider, and report main issues back to IMCA Strategic Group on a quarterly basis.

3.2 Records of all IMCA activities relating to each LA would be made available to the Contracting Officer on a quarterly basis. This would enable the Strategic Group in addressing potential under or overspends. (Refer to Terms of Reference)

3.3 The Contracting Officer will be managed by Rotherham MBC contracting department and operate to RMBC’s policies and procedures. She/He will have accountability to RMBC and the IMCA Strategic Group.

4.0 **Dispute Resolution**

4.1 The Contracting Officer on behalf of all four LA’s will aim to resolve any disputes at the earliest opportunity.

4.2 Beyond this initial stage, any conflict will be addressed as per Terms of Reference, with escalating degree of seniority. Whilst it will be onerous for one LA to take the lead in resolving dispute above the Strategic Group stage, each LA could take an annual rotational role in nominating an Assistant Director level representative, beginning with RMBC and then alphabetically afterwards.

5.0 **Financial Arrangements**

5.1 Sheffield City Council will invoice RMBC, BMBC, DMBC for the IMCA start up costs before end of March 2007. This monies to be used for the tendering and advertising costs, as well as supporting speaking up in their set up costs.
5.2 From April 2007, Sheffield to invoice other 3 LA’s for 80% of their IMCA allocations as per contract.

5.3 Subject to certain agreements in 3.2, provisions should be in place for each LA to borrow (in case of overspends) from another LA for that particular financial year. This arrangement must be on a reciprocal basis, once the 20% buffer – minus Contract Officer costs – have been exhausted.

5.4 Rotherham MBC to invoice Sheffield CC for the pooled Set Up costs towards the recruitment and establishment of the Contracting Officer post. Any remaining monies from the set up costs and the 20% of IMCA allocations will be held by each LA for spot purchasing activities.

5.4 Payments are to be made to Service Provider monthly in arrears. This could be triggered by an automatic payment process.

5.5 If performance and contract monitoring highlights specific issues relating to standards. The service provider would be given an agreed period of time to address highlighted issues. If the turnaround period has lapsed and the performance is still not to the standard expected, then further action will be taken in line with Section 18 of Contract.

6.0 Communications

6.1 Performance and Contract meetings are to be formally minuted and filed. All contract monitoring meetings should highlight actions, timescales and responsible persons.

6.2 Reports by the Contracting Officer should be sent to the chair, who would be responsible for cascading to Strategic Group members prior to meetings.

7.0 Review

7.1 This IMCA protocol should be reviewed annually by the Strategic Group, or earlier, subject to further guidance as issued by Government.

Final Version
1st April 2007

Kwai Mo
On behalf of South Yorkshire IMCA Group
References

1) Mental Capacity Act 2005


5) Policy Statement – Criteria for the use of IMCA’s in Safeguarding Adults Cases Draft 2 (March 2007) – ADSS Group

6) Safeguarding Adults - South Yorkshire Adult Protection Procedures – (March 2007)


8) Adult Protection, care reviews and IMCA: Guidance on interpreting the regulations extending the IMCA role: DH – (Jan 2007)
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>My client is funded from outside the County I work in, which IMCA service is the right one?</td>
<td>The right service is the one based in the County where the person is currently residing, even if they are staying there on a temporary basis such as a hospital stay.</td>
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<tr>
<td>Are there any costs involved in accessing IMCA?</td>
<td>There is no cost to individual organisations or services. The service is commissioned by the Local Authority.</td>
</tr>
<tr>
<td>Who is the service for?</td>
<td>Adults who lack capacity to make a particular decision. This will include, for example, people who have learning difficulties, mental health problems, brain injuries, neurological conditions or dementia. The decision <strong>must</strong> be about serious medical treatment or a change of accommodation and the person must not have family or friends who the decision-maker considers to be appropriate to consult. In other words where there is no-one who can be consulted other than people engaged in the person’s care or treatment in a professional or paid capacity, IMCA must be involved. In addition the Local Authority has powers to involve IMCAs in decisions relating to Adult Protection Procedures or Care Reviews. Please refer to additional guidance.</td>
</tr>
<tr>
<td>Is there a minimum age?</td>
<td>The minimum age is 16.</td>
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<tr>
<td>Who is responsible for deciding whether or not a person lacks capacity to make a decision about serious medical treatment or a change of accommodation?</td>
<td>Steps should be taken to ascertain whether a person has the capacity to make a particular decision. For example, the person should be given all the relevant information in a format which is accessible to them. Support should be given to enable them to understand the information and communicate their decision. If the person then appears to lack capacity to make the decision in question, an assessment of the person’s capacity in relation to the decision should be made. It is the decision-maker’s responsibility to decide if the person lacks capacity. The Mental Capacity Act Code of Practice says that the more serious the decision, the more formal the assessment of capacity may need to be. There is further guidance in the Code of Practice about how assessment of capacity should be carried out.</td>
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<tr>
<td>What is meant be serious medical treatment?</td>
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<th>What changes in accommodation qualify people for IMCA?</th>
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<tr>
<th>Who is the decision-maker?</th>
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<th>What is meant by family and friends who are ‘appropriate to consult with’?</th>
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## How do we make a referral?

Referrals can be made by telephone, letter, fax or email. We will ask you to complete a Speaking Up IMCA referral form which is available on request. We aim to respond very quickly to any referrals received.

<table>
<thead>
<tr>
<th>IMCA Referral Line:</th>
<th>0845 650 0081</th>
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<tbody>
<tr>
<td>IMCA FAX</td>
<td>0845 650 0081</td>
</tr>
<tr>
<td>IMCA email:</td>
<td><a href="mailto:imca@speakingup.org">imca@speakingup.org</a></td>
</tr>
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</table>
IMCA
Independent Mental Capacity Advocate Service
Guidelines for Referrers

This is an information sheet for referrers to help clarify what IMCA can offer. Please consider the following points when considering whether a referral to IMCA is appropriate.

People who need IMCA are likely to be facing a crisis. It is therefore important that referral procedures are agreed and followed by all parties so that effective advocacy support can be provided as soon as possible.

1. IMCA provides advocacy to people aged 16+ who lack capacity to make a particular decision about serious medical treatment or changes in their accommodation. Additionally, Local Authorities may request that an IMCA is involved with a decision related to Adult Protection Proceedings or a Care/Accommodation Review.

2. To be eligible for the service clients must meet all the following criteria:
   - Lack capacity to make the particular decision.
   - The decision must be about either
     a) serious medical treatment
     b) a change in accommodation or decisions related to
     c) Adult Protection or a Care Review
   - The person does not have family or friends who can speak up for them. This does not apply in the case of Adult Protection Proceedings.
   - However, where a person has family or friends whom the decision maker considers may not be appropriate (see separate guidance) or where it may be impractical to consult with them, IMCA should be involved.

3. People who are detained under the Mental Health Act are not eligible to receive a service from IMCA unless the decision involves medical treatment not related to their mental health problems (e.g. cancer) or a change of accommodation as long as the accommodation proposed is not a condition of their discharge.

4. Referrals can be made by anyone who recognises that a person who lacks capacity is eligible for IMCA due to a situation described above. The person responsible for making the best interest decision will need to be identified.

IMCA referral line: 0845 650 0081
Independent Mental Capacity Advocate Service
IMCA
Additional guidance on client eligibility for the service

Feedback from health & social care practitioners indicates that the criteria of having family who are ‘willing and able to be consulted’ about the decision is causing some difficulties when deciding if a referral is relevant or not.

If a person is facing a decision about a change of accommodation or serious medical treatment, has been assessed to lack the capacity to make that decision and has **no family or friends** who can be consulted about the decision then they are definitely eligible for IMCA.

If in the same situation described above a person **does have family or friends** a decision needs to be made about whether the person needs an independent mental capacity advocate. The term used in the Mental Capacity Act is that family or friends may not be ‘appropriate to consult’.

In the following situations, a referral should be made:

- The family member or friend is not willing to be consulted about the best interest decision.
- The family member or friend is too ill or frail.
- There are reasons which make it impractical to consult with the family member or friend eg they live too far away.
- The person named by the client to be consulted feels that they do not know the person well enough to be involved.
- There is intense conflict within the family or with family and professionals about what would be in their relative’s best interest.
- There are allegations, suspicions or proved incidences of abuse by the family member or friend.
- The family member or friend is unwilling to involve the person whom the decision is about in the decision-making process.

For further information please contact the IMCA referral line 0845 650 0081 or imca@speakingup.org
GLOSSARY

Abuse - A violation of an individual's human and civil rights by any other person or persons. This could include acts and omissions and be intentional or unintentional.

Advocate - A paid worker or volunteer who has been trained in order to support people by helping them represent their views.

Alerter - Anyone who has contact with vulnerable adults and hears disclosures or allegations, or has concerns about potential abuse or neglect has a duty to pass them on appropriately.

Approved Social Worker (ASW) - Social Workers appointed to undertake assessments under the Mental Health Act 1983.

Care programme approach (CPA) – The process which mental health service providers use to co-ordinate the care for people who have mental health problems.

Carer - A family member, friend or neighbour who takes on unpaid responsibility for someone who has a mental or other disability or whose health is impaired by illness or age. A carer may be eligible for an assessment of need.

Care trusts - Organisations that work in both health and social care. They may carry out a range of services, including social care, mental health services or primary care services.

Care Worker - A person who is paid to provide personal/practical care to an individual.

Commission for Social Care Inspection (CSCI) - The single, independent Inspectorate for all social care services in England.

Commissioners - The branches of health and social care statutory organisations that purchase services from voluntary and independent sector organisations - through which they provide additional health and social care services to the public.

Criminal Records Bureau (CRB) - An executive agency of the Home Office which helps employers in the public, private and voluntary sectors to identify candidates who may be unsuitable for certain work, especially that involving contact with children or other vulnerable members of society.

Direct payments - Financial resources given to people so that they can organise and pay for the services that they need, rather than use the services that the council offers.

Disclosure - Action by an adult to communicate, in any way, that abuse has occurred.
**Duty of Care** - Involves taking reasonable care to avoid acts or omissions which are likely to cause harm to another person. Under common law, decisions to act can be made in the best interest of an adult who does not have mental capacity.

**Fair Access to Care Services (FACS)** - Guidance issued by the Department of Health to councils and care trusts about fair charging policies for home care and other non-residential care, and advice about eligibility criteria for adult social care.

**Healthcare Commission** - This promotes improvement in the quality of healthcare in England and Wales. In England this includes regulation of the independent healthcare sector.

**Investigator** - Practitioners from Health & Social Care and the Police, who coordinate the collection of the information about the alleged abuse or neglect.

**Mental Capacity** - a person’s ability to make a decision for himself or herself, i.e.:
- To understand the information relevant to the decision
- To retain the information
- To use or weigh that information as part of the process of making the decision
- To communicate his decision by any means.

**National Service Frameworks (NSFs)** - A set of national standards and identify key interventions for a defined service or care group; put in place strategies to support implementation; and establish ways to ensure progress within an agreed timescale.

**Partner agency** - One of the organisations who is a member of a group of organisations working together in partnership to achieve common objectives.

**Primary Care Trusts (PCTs)** - The local health organisations responsible for managing local health services. PCTs work with Local Authorities and other agencies that provide health and social care locally, to make sure the community’s needs are being met.

**Protection of Vulnerable Adults (POVA)** - A list of those registered as being unsuitable to provide care to ‘vulnerable adults’. Through referrals to, and checks against the list, care workers who have harmed a vulnerable adult, or placed a vulnerable adult at risk of harm (whether or not in the course of their employment), will be banned from working in a care position with vulnerable adults.

**Regulatory Authority** - The body responsible for the registration, inspection, complaints, investigation and enforcement of the requirements contained in the Community Care Act 2000

**Risk Assessment** - The holistic and systematic process of identifying and quantifying the personal, social and environmental hazards in a person’s situation.
**Risk Management** - A clear plan which takes into account the types and level of risk and attempts to reduce the risks by means of a range of interventions.

**Safeguarding Adults** - Safeguarding Adults work means all activity, which enables an adult to retain independence, well being and choice and to be able to live a life that is free from abuse and neglect. It is about preventing abuse and neglect, as well as promoting good practice for responding to concerns on a multi-agency basis.

**Safeguarding Adults Board** - The formal group of organisations who are working together to implement ‘Safeguarding Adults’ work in a local area. The Board comprises people from partner organisations who have the ability to influence decision-making and resource allocation within their organisation.

**Safeguarding Manager** - A named person [usually from statutory agencies in Health or Social Care] who is responsible for overseeing the Safeguarding Assessment and its outcome, including - making decisions on the need to investigate, or identifying alternative responses, convening and chairing strategy meetings, including the agreement of responsibilities, actions and timescales, and co-ordinating and monitoring investigations

**Service provider** - An organisation that delivers services, such as health and social care services.

**Service User** - A person who is a customer/consumer of a service (particularly used in relation to those using social care services).

**Single Assessment Process (SAP)** - Introduced in the NSF for older people, it aims to make sure older people's care needs are assessed thoroughly and accurately, but without procedures being needlessly duplicated by different agencies.

**Staff** - People employed on a paid or unpaid (voluntary) basis by an organisation to organise and deliver its services/product.

**Universal services** - Services provided to the whole community. These can include education and health, libraries, leisure facilities and transport.

**Voluntary, community and faith sector (VCF)** - Over half a million voluntary and community groups in the UK, ranging from small community groups to large national or international organisations.

**Vulnerable Adult** - Someone 18 years or over, with eligibility for community care services, who is at risk of abuse or neglect

**Zero Tolerance** - Non-acceptance of antisocial and especially criminal behaviour, with an emphasis on dealing effectively with every manifestation of the behaviour however large or small.