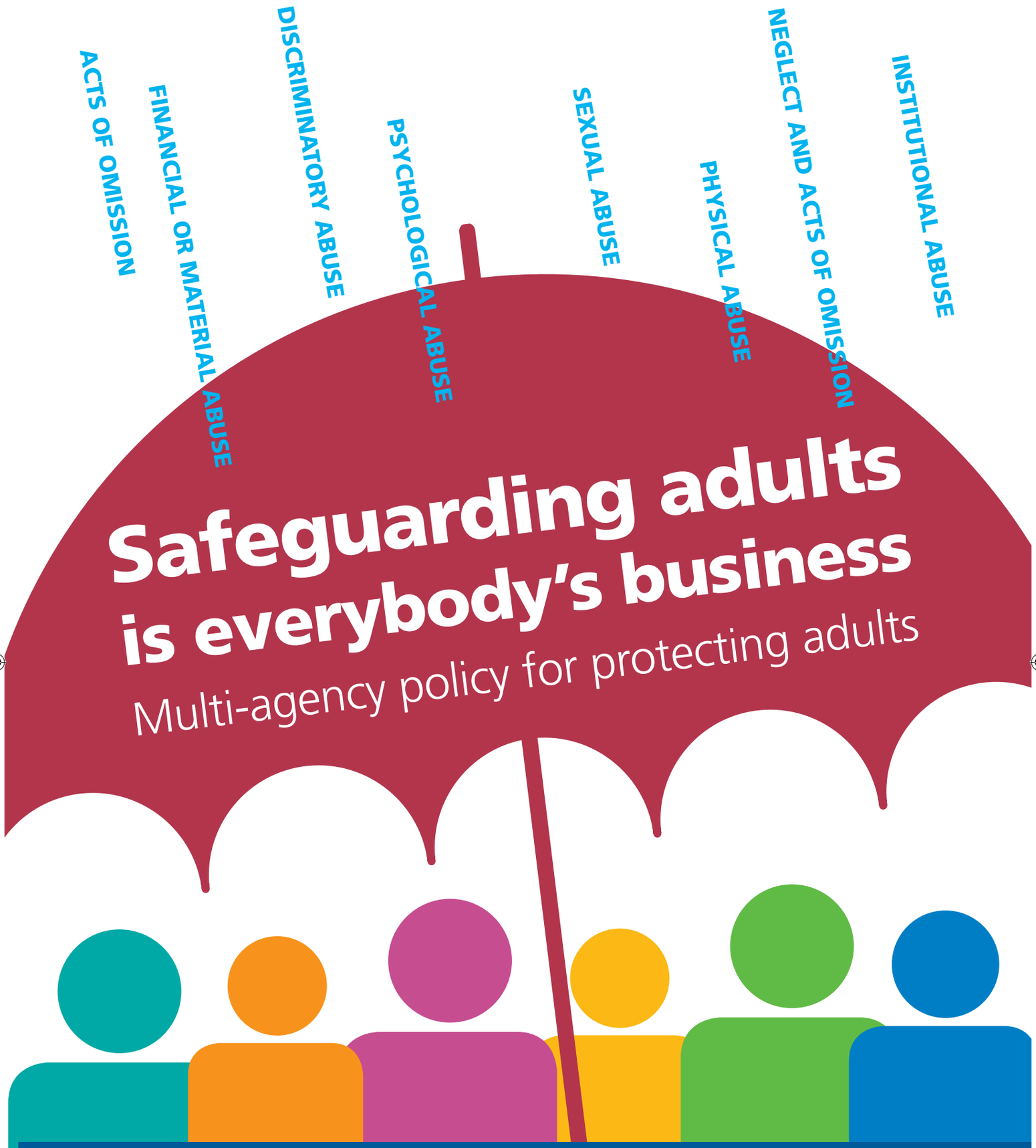

Safeguarding adults is everybody's business

Multi-agency policy for protecting adults

Southwark Safeguarding Adults Partnership

Version 2
Revised August 2008

Foreword

This document aims to assist staff within all agencies in promoting the prevention of abuse and to safeguard adults wherever abuse has occurred. It replaces the previous Adult Protection Policy and Procedures document.

This document represents a commitment by the agencies listed below, the Southwark Safeguarding Adults Partnership, to work together to prevent and respond to abuse wherever it occurs.

The importance of partnership working is stressed in the government guidance *No Secrets* (DH 2000) and best practice guidance *Safeguarding Adults - A National Framework of Standards for good practice and outcomes in adult protection work (*Association of Directors of Social Services 2005).

'Strong partnerships are those whose work is based on agreed policy and strategy, with common definitions and a good understanding of each other's roles and responsibilities. These underpin partnership working in response to instances of abuse and neglect, wherever they occur.' (*Safeguarding Adults*)

The Policy and Procedures consist of two documents and should be used in conjunction with each other. The Policy document (Part 1) gives an overview of the values and legal framework that underpin safeguarding adults work in Southwark together with general guidance on such topics as working with the police. The Procedures document (Part 2) gives detailed step-by-step instructions for staff on what to do if there is a suspicion or allegation of abuse.

These Safeguarding Policy and Procedures take precedence over any internal policies and procedures within all agencies whether statutory, independent or voluntary. Working together in a strong partnership within clearly understood and shared guidelines is the most effective means of combatting adult abuse and demonstrating zero tolerance of its occurrence in Southwark.

Revised August 2008

Signatories

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To achieve the greatest benefit it is expected that all the above agencies will be committed to:

- Provide ongoing training and support for staff
- Consult with users and carers
- Liaise with other agencies through the Safeguarding Adults Partnership Board
- Integrate these procedures into each agency's own policy and working practice
- Review and develop the procedures and practice through the Safeguarding Adults Partnership Board
- Provide support and ensure that sufficient resources are made available to meet their responsibilities within this work.

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Equality & Diversity Statement

The diversity of our community is one of our most valued assets. Strong communities will thrive and prosper if individuals and groups are treated fairly, with respect, and given access to rights and services. Our aim is to create an environment where this is possible and to put equality and diversity at the heart of everything we do.

We will promote equality and diversity by:

- Building values of mutual respect where individuals have a sense of belonging and where individuals are encouraged to participate and gain full access to services to which they are entitled.
- Recognising that some individuals and certain communities are particularly disadvantaged and will require extra recognition and support to deal with their disadvantages.

Our aims are:

- To improve the quality of life by improving access to services and by reducing gaps in health, employment, education attainment and community safety - particularly with those most affected.
- To improve social cohesion by promoting positive relationships and a sense of community and belonging – by reducing fear and tensions – particularly around race, faith and generational issues, – by promoting a vision in which individuals, groups and communities are properly valued.
- To promote citizenship rights and responsibilities. We will do this by ensuring that the Council does all it should in providing real leadership and compliance with its duties and by encouraging its partners, particularly in the public sector to do likewise. We will also do this by acting to protect the rights of individuals and groups by ensuring that abuse, mistreatment or discrimination is recognised and properly dealt with.
- To promote a workforce which understands and is committed to achieving these goals and retains the confidence of our local communities.

Preface

No Secrets (Department of Health 2000) Guidance emphasised the growing problem of the abuse of adults with community care needs and demonstrated the determination of Government to tackle the issues of adult protection. It highlighted the importance of the multi-agency response from all sectors including health and social care and the criminal justice agencies.

No Secrets (DH 2000) is one of a range of linked initiatives, the most recent being *Safeguarding Adults* (Association of Directors of Social Services 2005), which has been embraced by the Safeguarding Adults Partnership Board and incorporated in to these procedures. The Framework builds on and takes further the spirit of No Secrets. It reflects the need for any action taken to be 'proportionate to the perceived level of risk and seriousness' of a given situation (*Safeguarding Adults*).

Other initiatives include:

- The introduction of the Human Rights Act 1998
- Youth and Criminal Evidence Act 1999, with improvements in measures to support vulnerable witnesses
- The Care Standards Act 2000, which introduced the Protection of Vulnerable Adults Register (POVA), registration of staff working in the social care sector by the General Social Care Council (GSCC), and the regulation of care provision by the Commission for Social Care Inspection (CSCI)
- Fair Access to Care DH 2002
- The Mental Capacity Act 2005.

These measures are aimed at strengthening the role of public bodies in supporting and protecting adults who may be subject to abuse.

Planning, implementing and monitoring safeguarding adults work is a multi-agency responsibility, which is led by the Safeguarding Adults Partnership Board (SAPB) –the new name for the Adult Protection Committee as defined in *No Secrets*.

This document should be read in conjunction with the Human Resources disciplinary and complaints procedures of all relevant agencies and any information-sharing protocols involved in the process of safeguarding adults. Consideration also needs to be given to this document within the context of any Health Trust incident policies and both processes should be used in parallel if abuse has occurred or is suspected.

This document must take precedence over any internal policies and guidelines within all agencies whether statutory, independent or voluntary in relation to safeguarding adults.

If the allegation involves a member of staff any actions taken against the individual must be in line with the organisation's own disciplinary procedures in all circumstances.

Employers and employees are required to act in accordance with these procedures with regard to any information brought to their attention that gives reasonable grounds to suspect that a 'vulnerable adult' has been abused.

Part 1 Policy

Chapter 1 of this document outlines the values and objectives of safeguarding adults work in Southwark, which are based on individual human rights and underpin all decision-making.

The introduction of *Safeguarding Adults* marked a step change in this area of practice together with a refocusing of the language and philosophy. It moved the emphasis away from merely responding to abuse once it had occurred to one that aims to prevent it. **Chapter 2** provides a framework to assist in the management and prevention of abuse.

In addition, *Adult Protection Data Monitoring* produced by Action on Elder Abuse (AEA) in 2006 recommended to the Department of Health that a national recording system and performance indicator be developed for adult protection work in England, Wales and Northern Ireland. These have been accepted in principle and may ultimately provide a more robust statistical information base for adult protection, support future practice, academic research and development. The AP1, 2 and 3 Forms have been based on these requirements (Appendices 1, 2, and 3).

Adult abuse can occur in many different situations and settings. It is usually a complex area of work and professionals need to be aware of the wide range of situations that may put a person at risk. **Chapter 3** defines who is at risk of abuse, its forms, indicators and factors leading to it.

The most disadvantaged groups are particularly vulnerable, and those working with disadvantaged people are likely to have to respond to abuse that is identified, disclosed or suspected. **Chapter 4** defines the roles and responsibilities of the various organisations involved in the safeguarding adults process. **Chapter 5** gives guidance on working with the police and preserving evidence, while **Chapter 6** provides information on managing inter-authority investigations.

Abuse can be identified and responded to more confidently where anti-oppressive practice is a core element of any intervention, and where there is clarity regarding gender issues and the vulnerable person's cultural needs. Research in this area of work is still quite limited. However, as this work develops it will inevitably shape and inform these procedures as they are revised in future. **Chapter 7** offers current best practice guidance for responding to a discovery or disclosure of abuse.

Chapter 8 gives direction to employees who feel unable to disclose suspicions or concerns through normal channels and outlines the 'whistle-blowing' procedure.

Chapter 9 considers the issues involved in relation to confidentiality and sharing information and how best to navigate this complex area. See the *Information Sharing Protocol* at www.southwark.gov/safeguardingadults, click on 'Policies, Protocols and Reports' page.

Safeguarding adults, unlike child protection has no single legal framework and relies on a range of social welfare and criminal law. This legislation is referred to throughout this document, but **Chapter 10** provides information on explicit legal remedies relating to specific types of abuse.

Part 2 Procedures and Appendices

This provides step-by-step instructions and timescales for all staff working in this area of practice on what to do if there is suspicion, concern or an allegation of abuse. Part Two is a stand-alone document, which is designed for those involved in the investigation.

It is our intention to review and revise this document on a regular basis in accordance with national developments and based on feedback from all practice areas. Please forward any comments and suggestions you may have to the Safeguarding Adults Co-ordinator (see Appendix 6 for contact details)

1 Values and objectives

An approach of **zero tolerance** will be taken to ensure that adults with community care needs are protected.

All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act 1998 to intervene proportionately to protect the rights of all citizens. These rights include Article 2 'The right to life'; Article 3 'Freedom from torture (Including inhuman and degrading treatment)'; and Article 8 'Right to respect for private and family life' (one that sustains the individual).

1.1 Core values that underpin Safeguarding Adults

All individuals are entitled to:

- Respect for privacy
- Be treated with dignity
- Lead an independent life and to be enabled to do so
- Be able to choose how they lead their lives so far as their mental capacity makes it appropriate.
- The protection of the law
- Have their rights upheld regardless of ethnic origin, gender, sexuality, impairment or disability, age, religious or cultural background.

Adults considered to be at risk of or who are experiencing abuse and who are able to make informed choices must be advised of the options available to them, and have their wishes respected unless, exceptionally, a statutory responsibility to intervene arises (for instance, because the safety of someone else is affected by what is going on). If intervention is necessary to prevent further risk, then staff should pursue lawful action in a way that causes the least disruption for that individual's way of life.

Where an adult is deemed not to have the capacity to make informed choices the priority in deciding which action to take must be to ascertain which of those available is in the person's 'best interests' ('common law' and 'Mental Capacity Act 2005').

This policy document is one part of a set of systems including other internal policies, procedures and criminal and civil law that are in place to protect those adults in need. It must therefore be used in conjunction with all these systems. It is also important to provide high-quality services that encourage and value the views and opinions of users, carers and staff, as a preventive deterrent measure regarding abuse arising in the first place.

1.2 What are Community Care Services?

'Community care services' are defined in s.46 of the National Health Service and Community Care Act 1990 (NHSCCA) as services which a local authority may provide or arrange to be provided under a range of statutes. The most **commonly** used provisions are the National Assistance Act 1948, sections 21 (provision of accommodation) and 29 (provision of a range of non residential services).

Section 21 National Assistance Act 1948 and Secretary of State Approvals and Directions impose a duty on local authorities to provide accommodation in general to adults who are ordinarily resident in the local authority's area and in some instances to adults with no settled residence or in urgent need.

*'who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them' NB The interpretation section in the NAA clarifies that 'disability' includes **mental** as well as physical disability.*

The Chronically Sick and Disabled Persons Act 1970 (applying to those who are ordinarily resident) and **Section 29 NAA and Secretary of State Approvals and Directions** require local authorities to make arrangements to provide facilities for occupational, social, cultural and recreational activities and for social rehabilitation and

adjustment to disability including assistance in overcoming limitations of mobility or communication, to promote the welfare of (in general) adults **ordinarily resident** in the local authority's area:

'who are blind, deaf, dumb, suffer from mental disorder or are substantially handicapped by illness, injury or congenital deformity or such other disabilities as may be prescribed by the minister.'

1.3 Duty to Assess

S47 National Health Service and Community Care Act 1990 imposes on local authorities a duty to assess persons who appear to be in need of community care services. Having regard to the results of the assessment a decision must be made as to whether the persons needs call for the provision of services by the authority.

To ensure that limited resources go as far as possible and are applied to those most in need local authorities develop **eligibility criteria** and in this way an authority may set its thresholds for need and whether or not it is necessary to meet the need, thereby discharging the underlying statutory duties or powers mentioned above.

1.4 Eligibility criteria

Fair Access to Care (DH 2002) stresses the 'risk to independence and well-being' as the key criteria for determining eligibility criteria for 'Community Care Services'. This introduced the principle of undertaking an assessment of the risk posed by the abuse and neglect to the quality of life for the individual concerned. The emphasis now is therefore on supporting adults to access services of their own choosing rather than 'stepping in' to provide protection *Safeguarding Adults* (ADSS 2005) subject, of course, to mental capacity, in the sense that there may still be a duty to care for those who lack the capacity to take decisions regarding the risks to which they may be being subjected.

1.5 Objectives

The above will underpin all work and decision-making within safeguarding adults including the following objectives:

- To investigate any allegations or suspicions of abuse or exploitation promptly and thoroughly in line with these policies and procedures
- To monitor outcomes of all situations investigated and, through the Safeguarding Adults Partnership Board, use this information to develop and improve policy, procedures and practice
- To learn from all situations investigated and to use what we learn to protect adults from abuse or exploitation in the future
- To ensure that this policy will be used as guidance for the investigation of allegations and/or suspicions concerning adults who are resident in the London Borough of Southwark and those who have been placed outside of the Borough by the Health and Social Care Department. This policy also extends to include people who fund their own care within Southwark.
- To recognise that this document must not be seen in isolation but is part of the overall corporate agenda and responsibilities within the broader framework of safeguarding adults including: housing opportunities, workforce development, multi-agency training and access within the criminal justice system.

Adults who refuse care/services or self-neglect

Those adults who screen themselves out of services and are at significant risk because of their refusal of care services and interventions are to be dealt with through the processes of Risk Assessment, Care Management and the Care Programme Approach.

In all these cases the person's capacity must be considered. In such situations the most relevant aspects of mental capacity are understanding and of the ability to make informed decisions about safety from abuse and neglect *Safeguarding Adults* (ADSS 2005).

1.6 Vulnerability vs mental incapacity and its significance for safeguarding adults functions

Whilst vulnerability is indeed a factor triggering a right to assessment, and potentially a duty on the part of the local authority to take steps without the individual's consent, mental incapacity is the foundation of all adult protection mechanisms involving actual intervention through lawful means by local authorities.

A case called **A local authority v Mr Z** in 2004 explored the foundations of adult protection powers, and identified that they come from a combination of

- Care management assessment and provision functions under the 1990 Act and other specific community care legislation
- The inherent jurisdiction of the High Court to grant declarations identifying the best interests of incapacitated adults
- The common law doctrine of necessity that covers anyone involved in caring for incapacitated adults
- The Mental Health Act 1983 in so far as it provides for powers of entry and guardianship in specific situations
- The Human Rights Act 1998 imposing a positive duty on the part of the State to ensure that mechanisms are in place to protect the human rights of those not able to assert them for themselves.

The judge held that the court had no basis in law for exercising the jurisdiction so as to prohibit the mentally capacitated wife from taking her own life.

- The local authority had a duty to investigate the position of the wife as a **vulnerable** person and to consider whether she was legally competent, and to consider whether to invoke the jurisdiction of the High Court if necessary and exceptionally to invoke that jurisdiction.
- Its duty did not extend, where the person was competent, beyond giving advice or assistance in accordance with the person's perceived best interests and informing the police if a criminal offence might be involved.
- The local authority had no duty to seek the continuation of the injunction.
- The court would not of its own motion continue the injunction where no one with the necessary standing sought any such order, where the criminal justice agencies had the necessary powers to prosecute any breach of the criminal law and where the effect of the injunction was to deny to a seriously disabled but competent person a right that could not be exercised by reason of the disability.
- The judge even said, in relation to capacitated adults: "Human freedom, if it is to have real meaning, must involve the right to take what others may see as unwise or even bad decisions in respect of themselves; were that not so, freedom would be largely illusory"…. "In the circumstances here [full mental capacity], Mrs Z's best interests are no business of mine"

He went on to identify the duties of local authorities in adult protection cases:

i) To investigate the position of a vulnerable adult to consider what was his/her true position and intention;

ii) To consider whether any other (and if so, what) influence may be operating on his/her position and intention and to ensure that s/he has all relevant information and knows all available options;

iii) To consider whether s/he was legally competent to make and carry out his/her decision and intention;

iv) To consider whether to invoke the inherent jurisdiction of the High Court so that the question of competence could be judicially investigated and determined;

v) In the event of the adult not being competent, to provide all such assistance as may be reasonably required both to determine and give effect to his/her best interests;

vi) In the event of the adult being competent, to allow him/her in any lawful way to give effect to her decision although that should not preclude the giving of advice or assistance in accordance with what are perceived to be his/her best interests;

vii) Where there are reasonable grounds to suspect that the commission of a criminal offence may be involved, to draw that to the attention of the police;

viii) In very exceptional circumstances, to invoke the jurisdiction of the court under Section 222 of the Local Government Act 1972 to enforce the criminal law by injunction.

2 Preventing abuse

2.1 Prevention

'If all adults were able to effectively access support to live safer lives at the time they needed it, there would be no need for policies and procedures aimed at addressing the needs of specific groups of people' Safeguarding Adults. However, it is recognised that some groups of adults experience a higher prevalence of abuse and neglect than the general population and they may not easily be able to access services to enable them to live safer lives.

Prevention therefore plays a key role in ensuring that 'all persons have the right to live their lives free from violence and abuse' (Human Rights Act 1998)

Abuse can occur in any setting and all staff should be vigilant in relation to it.

There are many reasons why abuse may occur and there are also different ways of preventing certain forms of abuse. People can be abused in their own home, in residential and nursing homes, in day centres, at work, in hospitals, police stations and public places. This document provides a framework to assist in the management and prevention of abuse.

2.2 Risk assessment

Prevention plays an important role in safeguarding adults. To this end the assessment and management of risk is key within the process. (A sample risk assessment form is shown in Appendix 5. *Summary of risk for adults living in residential and community settings*.) This tool should be used when staff have concerns about the potential for abuse and concerns about the mental capacity of the person to make his or her own informed.

The risk assessment should inform the development of a safeguarding plan that will define:

- What steps are or have been taken to assure the person's safety in the future
- How services may be modified to meet their needs
- How to support carers or staff
- How to put in place an ongoing risk management strategy
- How to monitor the situation in the future.

The risk assessment should also give pointers to how services may be altered in the future to reduce the incidence of abuse. It should also consider the support needs of both the abused person and those of the staff or informal carers involved in the care and support of that person.

2.3 Care Standards Act 2000

Under the Care Standards Act 2000 the Commission for Social Care Inspection (CSCI) has set down National Minimum Standards for each of the social care settings they regulate, including residential, nursing and domiciliary care.

Depending on the setting, these Standards are geared to achieving certain outcomes including the following:

- That service users' health care needs are fully met, and their health, safety and welfare are promoted
- That service users feel they are treated with dignity, respect and valued as a person, and that their right to privacy is upheld
- That service users are helped to exercise choice and control over their lives
- That service users are protected from abuse, neglect and self-harm
- That service users have their rights protected and their complaints listened to, taken seriously and acted upon.

This policy document also seeks to achieve these outcomes as part of its prevention and safeguarding adults agenda, subject to issues of mental capacity.

2.4 Training

Training plays a key role in prevention so the provision of appropriate training and support for staff employed to work with adults in need is crucial. Joint training across all relevant agencies is proven to break down barriers and improve understanding and joint working and should be undertaken where possible. Training and its outcomes should be monitored and reviewed by the Safeguarding Adults Partnership Board.

All training in safeguarding adults work should be aimed towards developing safe working practices, increased user and carer involvement in services as well as an increased awareness of abuse and how to report it.

It is expected that all agencies involved in safeguarding adults will develop training opportunities and a training structure that reflects that shown in Appendix 8 Training Pathway.

Safeguarding adults training should always highlight the relationship between poor practice and abuse.

3 Recognising abuse

3.1 Who is at risk of abuse?

An adult who may be vulnerable to abuse is defined in *No Secrets* as being someone aged 18 or over *'who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or maybe unable to take care of his or herself or unable to protect his or herself against significant harm or exploitation'* (Law Commission Report 231, 1995).

An individual is vulnerable when *'their health or usual function is compromised or when they enter unfamiliar surroundings'.*

3.2 What is abuse?

'Abuse is a violation of an individuals human and civil rights by any other person or persons' No Secrets (DH 2000).

Within this context consideration needs to be given to a number of factors:

- Is it a single or repeated act?
- Is it physical, verbal or psychological?
- Is it an act of neglect or an omission to act?
- Has the person been persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent?

3.3 Types and indicators of abuse

The following is a guide only and not an exhaustive list

3.3.1 Physical abuse

The use of force that results in pain or injury or a change in the person's natural physical state

Examples

- Hitting/Slapping
- Punching
- Shaking
- Excessive restraint
- Pinching
- Enforced sedation
- Scalding
- Forced feeding
- Burning
- Catheterisation for 'ease of management'

Factors that may indicate abuse

- Sprains
- Welt marks
- Fractures
- Cigarette burns
- Dislocations
- Bruises (especially in protected areas)
- Pressure sores
- Drowsiness, confusion due to over-sedation
- Lacerations
- Delays in seeking medical attention
- Black eyes
- Unexplained injuries
- Anxiety or fear more evident in the presence of a possible abuser

3.3.2 Sexual abuse

Every person has a right to engage in sexual activities that are lawful and wanted and understood without being exposed to exploitation or sexual violence. Sexual abuse is defined as the involvement of an adult in sexual activities or relationships that:

- They do not want and/or have not consented to
- They cannot understand and are not able to consent to
- Sexual activity between employed staff and an adult receiving care and support is always exploitative and abusive.

Examples

- Enforced sexual contact
- Penetration or attempted penetration of vagina, anus, mouth, with or by penis, finger(s), other objects
- Harassment
- Sex for reward
- Enforced witnessing of sexual acts or sexual media
- Pornographic photography
- Serious teasing or innuendo

Factors that may indicate abuse

- Changes in behaviour (e.g. more withdrawn, depressed, confused, fearful, agitated)
- Difficulty in walking or sitting; torn, bloody or stained underclothes
- Pain or itching in the genital area
- Bruising or bleeding in external genitalia, vaginal or anal areas
- Venereal disease
- Increased sexualised behaviour

3.3.3 Psychological Abuse

Behaviour that has a harmful effect on an adult's emotional well being and development

Examples

- Intimidation
- Lack of stimulation
- Racist abuse
- Shouting
- Humiliation
- Swearing
- Insults
- Ignoring
- Confining or locking someone in enforced isolation
- Depriving an individual of the right to choice, information, privacy, dignity or respect
- Preventing access to other people in the home
- Absence of warmth, support or human contact

Factors that may indicate abuse

- Fear
- Confusion
- Low self-esteem
- Loss of independence
- Behaviour which is out of character
- Passivity
- Uncontrolled /unprovoked crying
- Unusual weight loss
- Anxiety/mental anguish
- Wandering
- A lock on the outside of the room
- Disturbed pattern of sleep
- Depression and withdrawal
- A physical environment that does not allow access to other parts of the home

3.3.4 Financial or Material Abuse

Use of another person's property, assets or income without their informed consent or making financial transactions that they do not understand (unless this is legally sanctioned and in accordance with the fiduciary duty owed to the incapacitated person

Examples

- Stealing or misappropriating money
- Deprivation of money/benefits
- Taking possessions
- Using pressure to obtain rights to property
- Pressure to give money away, including in will
- Fraud

Factors that may indicate abuse

- Presentation of legal documents requiring signatures
- Sudden and/or large withdrawal from bank/building society/post office
- Homelessness

- A 'disappearing pension'
- Inadequate clothing
- Inadequate heating/lighting
- Malnutrition
- Inadequate money to pay bills etc.
- Legally appointed financial representative not paying bills.
- Insufficient money to purchase basic necessities
- Hypothermia

3.3.5 Institutional abuse

Regimentation of residents/users of a service

Examples

- Undue restraint – may be due to staff shortages
- Limited access to drinks outside of specified times
- Lack of choice about bedtimes, meals etc.
- Denial of privacy e.g. absence of screens, leaving the toilet door open, failing to knock etc.
- Lack of supervision resulting in intentional/ accidental harm, poor management of risk, poor personal care
- Lack of stimulus or recreational activity
- Lack of consideration of a persons language, cultural or dietary needs
- Punishment for perceived 'bad' behaviour
- Lack of care
- Personal possessions or money used for someone else
- (Also see financial and psychological abuse above)

Factors that may indicate abuse

- Punitive treatment of resident, staff and residents
- Low staff morale
- Poor management awareness of legal developments and practice– resulting in difficulty for staff to feel safe to whistle-blow
- Lack of supervision and support for staff
- Low staffing levels over a prolonged period
- Lack of knowledge about care standards; staff factions and high staff turnover
- Staff ordering residents around
- Lack of communication amongst management
- Low level or absence of staff training
- High sickness rates

3.3.6 Discriminatory abuse

Behaviour that is racist, sexist, and harassment based on a person's ethnicity, race, culture, sexual orientation, age or disability, and other forms of harassment, slurs or similar treatment.

Examples

- Racial harassment
- Isolation from religious or cultural activities or antipathy to a religion or cultural activity

Factors that may indicate abuse

- Depression
- Confusion
- Refusal to accept support from services
- Not being offered and unable to access culturally appropriate foods or skin and hair care etc.
- Religious observances not encouraged or anticipated
- Isolation due to unsuitable placement and/or language barrier
- Feeling socially isolated

3.3.7 Neglect and acts of omission

Behaviour that leads to a person's basic needs not being met

Repeated instances of poor care may indicate more serious problems. Neglect and poor professional practice may suggest other forms of abuse such as institutional abuse particularly if this goes unchallenged.

Examples

- Failure to provide adequate health care
- Failure to administer medication according to prescription
- Failure to provide adequate food/drink
- Failure to provide a safe and adequately heated environment
- Failure to assist with appropriate levels of hygiene

Factors that may indicate abuse

- Dehydration
- Malnutrition
- Hypothermia
- Inadequate clothing
- Infections
- Pressure sores

Remember – don't write the script!

It should also be stressed that abuse may be happening even though none of these possible indicators are present.

If you have concerns that an individual might have been abused, discuss this with your line manager or Safeguarding Adults Co-ordinator.

If you feel, for whatever reason, you are not able to do this refer to Chapter 8. Whistle-blowing.

Remember you have a duty to report all concerns and suspicions of abuse.

Refer to the referral flow chart in Appendix 1

Some general behaviours linked to abuse

Staff should be aware of some signs that *may* indicate abuse, remembering that many of these indicators could also be signs of something else, for example an existing or undiagnosed medical condition:

- Seeking shelter or protection
- Unexplained reactions towards particular individuals
- Unexplained reactions towards particular settings
- Frequent or regular visits to the GP, or hospital casualty department, or hospital admissions
- Frequent or irrational refusal to accept investigations or treatments for routine difficulties
- Unexplained change in material circumstances
- Inconsistency of explanation or no explanation

3.4 Risk indicators

Where the following 'trigger' behaviours are apparent in a client, these may be additional indicators that abuse is occurring.

- Destruction of physical environment
- Turning night into day/sleep disturbance
- Chronic incontinence
- Extreme physical and/or emotional dependence
- Verbal abuse and aggression towards the carer
- Changes in personality not caused by illness and/or medication
- Non-compliance with carers' wishes
- Obsessive behaviour
- Wandering/absconding
- Self-harm

The following problems exhibited by the carer *may* increase the risk and likelihood of an abusive situation

- Alcoholism
- Mental illness
- Learning disability
- Stress
- Chronic fatigue
- Conflicting demands of other family members
- Individual unmet needs

4 Roles and responsibilities

It is important to note that within the spirit of joint working each agency needs to be aware of the distinct roles and responsibilities they have within the safeguarding adults process and within this Policy and Procedures document.

4.1 The Director of Adult Social Services

Has lead authority and responsibility for ensuring the protection of safeguarding adults with community care needs within their jurisdiction and for the co-ordination of any investigation taken under these procedures.

4.2 Adult Social Services

Social Services should act as the lead agency (*No Secrets*) for responding to and co-ordinating the work of all agencies involved in the protection of adults with community care needs and the investigation of any allegations of abuse for the specific purpose of minimizing risk and preventing continuation of the situation giving cause for concern.

They are responsible for supporting the service users involved in any investigation and protecting their best interests, if mentally incapacitated. They also lead on investigations and enquiries that do not constitute a criminal offence.

4.3 Social Services Commissioning Department

General statement:

Service Commissioners are responsible for managing and monitoring the local care market, ensuring service providers deliver community care services to meet the needs of the Southwark adult population to an appropriate model of care, an acceptable quality and standard and deliver Best Value in the discharge of the authority's primary statutory functions.

When negotiating contracts with providers Commissioning will ensure that working within the *Safeguarding Adults Multi-agency Policy and Procedures* is an explicit and integral part of any agreement.

Specific statement:

Service Commissioners support the safeguarding of adults process by working proactively with service providers to promote and operate the *Safeguarding Adults Policy and Procedures* within their organisations and to maintain the safety and well-being of adults placed under contract by Southwark Health and Social Care.

Service Commissioners' support to safeguarding adult investigations will focus on the performance of the provider and how any significant shortfalls will result in the abuse and/or neglect of a Southwark adult who is or may be eligible for community care services.

Service Commissioning attendance at safeguarding adult meetings and case conferences will be dependent upon the priority of the issues or case, as assessed from a commissioning perspective.

Any evidence of poor provider performance gained through commissioning monitoring or meetings with providers will be made available for safeguarding adult purposes and ordinary care management.

4.4 Commission for Social Care Inspection (CSCI)

Within adult care and safeguarding adults CSCI has a responsibility to register and inspect a range of services and to ensure that standards comply with legal requirements (for further information refer to the Care Standards Act 2000).

Social care services inspected by CSCI include:

- Care homes providing personal and/or nursing care
- Adult placement schemes
- Domiciliary care agencies
- Nursing agencies.

Following the passage in July 2008 of the Health and Social Care 2007/8 Act the 3 regulatory bodies CSCI, the Healthcare Commission and the Mental Health Act Commisssion will be abolished. They will be replaced by the Care Quality Commission (CQC) next April 09.

The CQC will have as its main objective the protection and promotion of the health, safety and welfare of people who use health and social care.

4.5 Independent advocacy services

They have a role in ensuring that the voice of the vulnerable person is heard, their wishes fully taken into account, and their rights protected.

4.6 Independent Mental Capacity Advocates (IMCA)

Under the Mental Capacity Act 2005 they have a role for those lacking capacity altogether, and without anyone to speak for them, in relation to specific Local Authority and NHS functions linked to serious medical treatment and long term accommodation arrangements.

See *IMCA Protocol* at www.southwark.gov/safeguardingadults, click on 'Policies, Protocols and Reports' page.

4.7 Independent and voluntary agencies

All organisations have a role in ensuring vulnerable adults are kept safe and are responsible for ensuring their procedures and practices complement this multi-agency document.

4.8 Hospital and Community based Health Staff

Hospitals and community-based health staff can have a crucial role to play when dealing with cases of adult abuse, either in initial identification, assessment or on-going monitoring and support. Staff in casualty departments may be the first people to identify a case of abuse.

In addition, hospital staff (this includes Doctors, Social Worker and therapy staff) and community based health care staff (this includes GP's, District Nurses Health Visitors, community-based mental health staff) can help in monitoring and supporting a client.

It is important to know how frequently a vulnerable adult presents in hospital either with injuries, other conditions or at the request of the carer/family.

In addition all organisations should have robust recruitment and selection systems, good supervision and management oversight arranagements and audit processes and a training structure, which aims to increase awareness of abuse.

Each of the agencies involved has a duty and responsibility to ensure that the rights and welfare of any adult involved in the procedures are protected. This includes the victim or perpetrator of the abuse, whether or not that person is another service user (so far as their legal and civil rights are concerned) or anyone who witnessed or reported it.

5 Working with the Police

The Police lead on any investigation where there is evidence that a criminal offence has occurred. To this end the Police must be involved when:

- There has been an allegation from an adult to another person of sexual abuse
- There is a suspicion that sexual abuse has occurred
- There has been an alleged or suspected case of physical injury that has caused harm to an adult constituting an assault, actual or grievous bodily harm
- An alleged or suspected case of cruelty. The offences include those whereby an adult is ill treated or neglected
- There are allegations or suspicions that involve unusual circumstances, e.g. organised or institutional abuse
- There is an alleged or suspected case of financial abuse.

If a situation is a matter of urgency and an immediate response is needed the Police should be contacted by dialling 999.

Non emergency crime allegations should be referred to the Community Support Unit, which is based at Walworth Road Police Station. This Unit not only deals with hate crime but domestic violence and certain crimes committed against vulnerable adults.

Referrals should be faxed to the unit using the AP1 Form (Appendix 1).

Community Support Unit Fax: 020 7232 6269

If you need to discuss any concerns with the police you should call the Community Support Unit Telephone: 020 7232 6195 (6237) (6160) (6218)

The Police working within the Community Support Unit will respond to referrals within 2 working days.

It is imperative that early consultation with the police should take place if there is any suspicion whatsoever that a criminal offence has been or may have been committed; failure to do this may lead to a loss and/or contamination of vital evidence.

(See Appendix 1 for a copy of the AP1 and Appendix 6 for local contact information).

It is the responsibility of the Police to investigate allegations of crime by gathering and preserving evidence. Where a crime is identified, the Police will be the lead agency and will direct investigations in line with legal and other procedural protocols.

It may be necessary for the Police to involve and inform other agencies and individuals as appropriate and in such circumstances there may be a need for joint investigations to be undertaken. Usually a safeguarding strategy meeting will be convened and it will be determined at that meeting how the investigation is to proceed and what is expected of each organisation represented. The local authority has no statutory function justifying investigation on behalf of the police and no statutory protection from ordinary civil suit for exceeding its remit in this regard.

The Police may also be involved in multi-disciplinary strategy meetings to consider any longer term issues raised. In any situation they should be able to offer valuable guidance over the phone as to whether any crime is apparent and what steps to take next.

The involvement of the police does not suspend or defer the ongoing statutory functions of the authority in relation to duties to meet eligible assessed needs, in a safe and appropriate manner, taking all relevant circumstances, such as perceived risk, given what is known or not known at this point, fully into account.

Evidence-gathering

It will always be the responsibility of the Police to gather and preserve evidence when a criminal offence is suspected. However, everybody working with vulnerable adults can play a part in preventing evidence being lost or contaminated.

Sexual assault

In cases of sexual assault swift collection and preservation of forensic evidence is vital to the success of a potential police investigation.

Forensic evidence may be found at the scene of the incident, on the clothing worn by the aggrieved, on bedding or other fabrics and surfaces. Where an alleged perpetrator is believed to have ejaculated or penetrated a victim, DNA evidence may be found in body orifices after differing periods of time. This DNA evidence can remain in the vagina for up to seven days, in the anus for up to three days and in the mouth for up to two days.

DNA can remain on fabrics even after they have been washed. Any clothing, bedding and other fabrics should be retained for forensic examination, with each item kept separately and packaged to avoid cross contamination.

If the use of Rohipnol ('date rape' drug) is suspected, this can be detected in the body for up to eight hours after ingestion.

A consensual medical examination should be carried out as soon as possible after an assault has taken place to obtain these evidential samples and identify any signs of trauma, including vaginal or anal tearing and bruising, which may have been caused during the alleged incident. Gentle persuasion may be needed to obtain the trust and understanding of the victim as to why this is necessary. If the client is incapacitated a best interest decision needs to be taken by the Police doctor concerned.

The Police may require their own forensic medical examiner (Police Doctor) to carry out these procedures so immediate referral to the Police will reduce any possible delays. You will also be advised as to how to support the alleged victim without contaminating evidence.

Physical abuse

Evidence of physical assault may be found through a medical examination for bruising, and in more serious cases, bone fractures. Visible bruising should be recorded on a body map. As bruising will fade each day please note the colour of the bruising and time, date, and locate on the body map to create the best possible evidence (see Appendix 1 for a sample body map).

Injuries may need to be noted by a forensic medical examiner or GP/Consultant and should be photographed with a ruler, or familiar object, next to the injury to indicate scale.

Financial abuse

Financial abuse may involve the falsifying of documents and their fraudulent use. These documents can be examined for fingerprints and handwriting analysis. All documentary evidence should be retained and carefully handled to avoid fingerprint contamination. It is important to keep a record of everybody who has had contact with the documents.

6 Inter-authority investigations

The Association of Directors of Social Services (ADSS) have produced a Protocol for Inter-Authority Investigations of Safeguarding Adults Referrals

This protocol aims to clarify the responsibilities and actions to be taken by local authorities with respect to people who live in one area, but for whom some responsibility remains with the area from which they originated.

This protocol should be read in conjunction with Section 3.8 of *No Secrets* (DH, 2000) and LAC (93) 7 *Ordinary Residence*, which identifies these responsibilities in terms of:

- The authority where the abuse occurred in respect of the monitoring and review of services and overall responsibility for adult protection
- The registering body in fulfilling its regulatory function with regard to regulated establishments
- The placing authority's continuing duty of care to the abused person.

(Refer to Appendix 7 for full version of Inter-Authority Investigation Protocol)

7 Best practice for responding to disclosures and/or discovery

Staff may become aware of the potential abuse of an adult with community care needs through their own or others suspicions or by the victim or abuser disclosing the abuse to them. It is important that staff respond to such disclosures in a way that is supportive to the person and mindful of the importance of the preservation of evidence if a criminal offence has occurred or is suspected.

Responding to disclosure

The manner in which you respond to a disclosure can have a marked effect on the outcome, both of any investigation and on the welfare of the person.

If there is any suspicion that a criminal offence has occurred contact the police without delay and ask for advice on how to manage the situation especially around recording what has been said and not contaminating evidence (see Appendix 6 for local contact details).

- Determine the views of the person about your proposed intervention. Even if they do not wish to take the matter any further, if a criminal offence may have occurred you have a duty to inform. In most cases the person will have the choice whether to take it further when the police offer them the opportunity to make a complaint against the alleged perpetrator.
- Listen very carefully to what you are being told.
- Record anything that is said immediately and sign, date and locate it. Records should be legible and of photocopy quality. Ensure that any opinions are clearly noted as such and are distinguishable from the facts.
- Do not ask detailed or probing questions – if in any doubt and a criminal offence has been committed contact the police for advice to ensure that potential evidence is not destroyed or contaminated.
- Reassure the person by telling them they have done the right thing in telling you, that you will treat the information seriously (if being told by the victim).
- Explain that you are required to share information with your manager and they might have to involve other agencies if appropriate.
- Be aware of the possibility of the need for forensic evidence.
- Reassure them that any further investigation will be carried out sensitively and that they will be supported throughout the process.
- Tell them what is likely to happen next so that they are prepared for possibly being interviewed. Reassure them that steps will be taken to support and protect them and that they will be kept informed.
- At the earliest opportunity inform your manager or senior member of staff.
- If no one is immediately available contact the appointed Safeguarding Adults Co-ordinator. See Appendix 6 for contact details.
- If the incident occurs or is likely to continue, outside of normal hours, you must inform the Out-of-Hours team, in case they need to get involved (see Appendix 6 for local contact details).

See Chapter 9 for further guidance on sharing information and confidentiality.

Assessment of urgency

An assessment of urgency including the presenting level of the risk to the adult should consider:

- Level of threat to independence
- Impact of the alleged abuse on the physical, emotional, and psychological wellbeing of all adults
- Duration and frequency of the alleged abuse
- Its degree and extent
- Level of personal support needed by the adult, and whether that support is normally provided by the alleged perpetrator
- Extent of premeditation, threat or coercion
- Context in which the alleged abuse takes place.

Remember that, although a single event may create a serious risk to the person's well-being, it is often the accumulation of events – each of which may appear small – that causes serious harm.

8 Whistle-blowing

All agencies whether from the statutory, voluntary, independent or private sector should have their own procedures to enable staff to express their concerns. These may be called 'whistle-blowing' procedures or codes of conduct/practice.

The client's interest is paramount and the common law 'duty of care' requires that each employee has a responsibility to:

- Draw attention to any matter they consider to be damaging to the interests of a service user, carer or colleague
- Put forward suggestions that may improve a service
- Correct any statutory omissions
- Prevent malpractice.

The Public Interest Disclosure Act 1998

People have in the past often been deterred from 'whistle-blowing' about abuse or neglect by duties of confidentiality and/or fear of the consequences of speaking out.

The Public Interest Disclosure Act seeks to protect disclosure of the following:

- A criminal offence (past, ongoing or prospective)
- Failure to meet a legal obligation
- A miscarriage of justice
- Health and safety being endangered
- Risk of environmental damage

OR deliberate concealment of any of the above.

The Act envisages that disclosure about such malpractice will generally be made in the first instance to the person's employer, or another person or body who appears responsible for the malpractice (e.g. a relative of a resident reporting matters to managers of a Home).

The Act envisages employers establishing procedures, so staff that may have justified concerns about breaches of practice or the law can pass on these concerns to be investigated.

Whistle-blowers are only protected by the Act if they are acting in good faith, and reasonably believe that their allegations are true. Allegations made for financial gain are not protected, even if they are true.

Staff making disclosures to people, other than their employer, are likely to be protected if:

- They reasonably believe that they will be treated detrimentally for disclosing to the employer
- They reasonably believe that the evidence will be destroyed or hidden if the employer is 'tipped off'
- The employer has been told, but has not taken appropriate action.

Disclosure to third parties must be a 'reasonable' step in all circumstances, including:

- Whom one tells (e.g. disclosure to a statutory inspectorate in preference to the press)
- How serious the concern is, and whether it is a continuing problem
- Whether the employer has a whistle-blowing procedure and if so, whether the employee has followed it
- In addition, if the failure is 'exceptionally serious' (a term not defined in the Act), it may be justified for the whistle-blower to disclose to a third party in the first instance, rather than their employer.

A disclosure made in accordance with the Act's expectations will mean that:

- No confidentiality clause in an employment contract can be used to prevent one from disclosing relevant breaches of the law or practice. This means that employers who are responsible for breaking a law, or for abuse or neglect or other malpractice cannot use confidentiality terms, in employment contracts.

Someone who is treated detrimentally at work because of making a disclosure that is protected by the Act can claim compensation at the Employment Tribunal.

Whistle-blowers will always:

- Be treated seriously
- Be treated confidentially where relevant
- Be treated in a fair and equitable manner
- Be kept informed of action taken and its outcome

Support and protection will be given to those providing information about abuse of adults with community care needs. If staff do not feel confident to report to their line management or using other internal methods such as the complaints procedure or advising the Safeguarding Adults Co-ordinator they can obtain advice from the following organisations:

- Your local Health and Social Care Services
- Commission for Social Care and Inspection. Tel: 0845 015 0120
- Action on Elder Abuse. Tel: 0808 808 8141
- Public Concern at Work. Tel: 020 7404 6609
- The Carersline. Tel: 0808 808 7777

All these contact details can also be found in Appendix 6 for local contact details.

9 Sharing information and confidentiality

Regardless of who reports/receives the initial information and or the referral, consideration must formally be given to notifying/reporting and involving all other appropriate interested parties. Where this involves the transfer of confidential information this should be done through formal channels and with clear understanding of why the information has been handed on. Any sharing of information must take account of the principle of proportionality, as required under the Human Rights Act 1998, and the European Convention on Human Rights as well as the Data Protection Act 1998, in regard to whether and with whom (i.e. with which agencies) the information will be shared.

Where possible the consent to share information should be obtained from the source. There are, however, lawful exceptions to the duty of confidentiality which include when:

- Explicit agreement is gained from the individual – this should preferably be in writing (any verbal agreement should be recorded with the date and time)
- Action is needed to protect the vital interests of a person who is unable to give consent or where it is not viable to obtain consent from them (as may be the position in cases of serious abuse or exploitation)
- Action is needed to protect the vital interests of other people, than the data subject, where the data subject has unreasonably refused their consent.
- Any duties or functions are based on legal, statutory or similar grounds (e.g. to carry out a community care assessment).

In general once an investigation is underway within the remit set out by *No Secrets*, information-sharing should be appropriate, linked to agreed actions and goals, and sanctioned by the strategy meeting. This approach supports an early decision to award adult protection inquiries 'formal investigation' status so that the issue of sharing otherwise confidential information on a need-to-know basis can be dealt with at an early stage as a standing item on the agenda of the safeguarding adults strategy meeting.

Each organisation must refer to its own internal policies, legal advice and guidelines with regard to information-sharing.

Sharing information about abuse or neglect of adults with community care needs

Investigating and responding to suspected abuse or neglect requires close co-operation between a range of disciplines and agencies. This will involve sharing information, which may be confidential to the source (the person who supplied it) and/or its subject (the person it is about).

Any decision to share information without the consent of the source and subject should be based on careful balancing of:

a) The rights of the source and/or subject to exceptions of confidentiality at common law, and restrictions on the right to respect for a private life under Article 8 of the European Convention on Human Rights (ECHR). The rights should be taken to include rights to reputation and livelihood, and the privacy of both ones home and correspondence and the harm likely to result from not sharing the information.

Practitioners should bear in mind the human rights of any person to be protected from treatment which is 'inhuman or degrading' (Article 3 ECHR), and the rights of potential victims and people thought to pose a risk to a 'fair hearing' under Article 6. Unless urgency or risk prevent, public law duties in relation to procedural fairness imply that people should be consulted about proposed disclosures which may affect them, and the reasons for disclosures and decisions should be explained. The right to a fair hearing means that people should be consulted about proposed disclosures which may affect them, and the reasons for disclosure decisions should be carefully recorded and explained.

Media involvement

With regard to decisions about information to be shared in the public domain following an adult protection investigation the department will take legal advice on a case-by-case basis. Press releases should be discussed and agreed by the partner agencies through involvement of the respective agencies' media or communications teams.

All staff must consult with their line manager regarding any requests for information and must not comment directly to the media concerning an adult protection allegation, concern or enquiry.

10 The Legal Aspects

Evidence of abuse and neglect

Successfully using the law to safeguard adults depends on having sufficient admissible evidence of any abuse or neglect that they have suffered and sometimes evidence of the lack of mental capacity for the person to have taken an informed decision around the continuation of the situation.

Bear the following in mind

- Make and sign detailed records as soon as possible after any disclosure or other significant information comes to light
- Factual evidence (i.e. what has been said or heard) can be given by any direct witness
- Indirect or hearsay evidence is not usually admissible in criminal proceedings
- Opinion evidence (e.g. about the severity of injuries, or the degree of risk) can only be given by someone appropriately qualified by training and/or experience.

Physical abuse

If there is sufficient admissible evidence, physical abuse may give rise to one of the following offences:

Assault/battery

Any blow or other physical contact without consent can constitute assault, as can an actual or threatened use of physical violence. It is in the nature of a 'common' assault that it may leave no physical evidence, and unless there are witnesses besides the alleged victim, successful prosecutions are rare.

There are separate and more serious offences, if the assault leaves evidence of injury:

- Actual bodily harm (ABH, section 47 Offences Against the Persons Act 1861) – this is any assault, which leaves a physical injury such as a bruise or a scratch
- Assault occasioning grievous bodily harm
- Grievous bodily harm (GBH section 18 and 20 OAPA) – this is an assault which causes a cut or break in the skin, serious damage to internal organs or broken bones.

Misuse of medicines

Under section 58 of the Medicine Act 1968 it is an offence to administer drugs which have been prescribed for someone else.

Sexual abuse

The following offences are of particular importance in protecting vulnerable adults under the Sexual Offences Act 2003, which came into force on 1 May 2004 and replaces the Sexual Offences Act 1956.

- Sexual Assault under section 3 of the Sexual Offences Act 2003 includes touching another person without consent in a sexual manner.
- Rape – this includes anal and oral rape
- Sections 64 and 65 of the 2003 Act prohibit sex with adult relatives, which includes uncles/aunts and nephews/nieces
- Sections 38–42 of the 2003 Act prohibit sexual activity on the part of a carer with someone who has a mental disorder. The offence does not depend on the victim being in a mental health setting or lacking capacity to consent, or on the carer being employed as such.
- Section 30 of the 2003 Act creates an offence of sexual activity with a person with a mental disorder impeding choice, which applies to any intentional sexual touching which the victim is unable to refuse because of a mental disorder. 'Unable to refuse' would apply to someone who lacks the capacity to choose whether to agree, and to someone who cannot communicate his or her refusal. Such people are also protected from being caused or incited to engage in sexual activity, or witnessing such activity (sections 34–37).

Compensation for abuses

Someone who has suffered physical or psychological trauma through abuse or neglect may (if they have capacity or have a Litigation Friend willing to act for them) be able to sue his or her perpetrator in the civil courts. However, because of the expense and delays of the court process and the difficulties of proving and attributing the trauma, it is usually more helpful to advise service users about the Criminal Injuries Compensation Scheme.

The scheme is available to compensate anyone who has suffered a trauma as well as physical injury, and financial losses such as the cost of therapy or lost earnings. As well as covering the direct victims of crimes of violence, the scheme also extends to indirect victims, for example those who have suffered through witnessing crimes committed against others.

An application can be made, even where no criminal charge has been brought. Application forms are available from the Criminal Injuries Compensation Authority (see Appendix 6 for local contact details).

Applications should be supported by reports from appropriate professionals, which should detail the physical and psychological trauma, and set out the general background to the application.

Applications generally must be made within **two years** of the incident(s) to be compensated, although this can be extended in exceptional cases.

Neglect

Despite the recommendation of the 1997 consultation paper *Who Decides?* there is as yet no offence of neglecting a vulnerable adult in one's care. If death results from neglect, a person can be guilty of manslaughter by omission, if they were grossly negligent (R v Stone 1976). But if the victim does not die, and is merely left worse off through neglect, use of the offence of wilful neglect is available under the Mental Capacity Act 2005.

Declaratory relief

This procedure is currently based on common law (i.e. previously decided cases) rather than specific legislation. When there are disputes as to what is in a person's best interests, individuals can apply to the court for a declaration otherwise known as declaratory relief.

The advantages of declaratory relief are as follows:

- Leverage for staff in relation to explaining the legal consequences of alleged abusers' actions.
- A jurisdiction creating a form of adult wardship which is accessible based only on a serious justiciable issue, and evidence of incapacity in relation to the issue in question – broader and more flexible than guardianship.
- Access to emergency injunctions from a duty Judge from the Family Division, to prevent removal from a care setting, by an alleged abuser, or to prevent removal of the vulnerable adult from the jurisdiction of the court, or to prevent a specific event such as surgery, or marriage; or to prevent access to a vulnerable adult by a third party.
- An independent skilled voice for the incapacitated adult in the shape of the Official Solicitor and/or a Litigation Friend, and access to funding from the Legal Services Commission, subject to means.
- A focus throughout the proceedings upon the best interests of the client, rather than on the guilt or innocence of the alleged abuser.
- Flexible and ongoing 'care and control' court orders in the name of the authority, protecting the authority against legal action for implementing what is sanctioned by the judge.
- Occasionally, when it is the only thing to be done, the means to provide a common law basis for a form of protective care, extending even to permission to restrain or detain an incapacitated individual for their own good.

The disadvantages of declaratory relief are the potential cost, the need to engage counsel, the difficulties of establishing incapacity when it is not related to a mental illness, but to an emotional or psychological dependency or 'blockage', and the limitations inherent in an order directed merely to clarifying the legal rights of the parties, as opposed to the existence of a specific statutory power to act and implement decisions based on risk assessment.

Many authorities have used this remedy since 1997,however, to achieve resolution of intractable impasses regarding adult protection concerns. Individuals with learning disabilities, or mental illness, or brain injury, or dementia, have been made the subject of such declarations, often resulting in the local authority achieving a clear legal basis out of the proceedings justifying their taking over the care of the adult in question. The cases tend to involve third parties who have either obstructed the local authority's care plan, physically, or by strenuous objection, or who have been doing something to an incapacitated adult that local authorities have felt no-one could feasibly objectively regard as necessary, and proportionate, to the situation of the incapacitated person.

Court orders of this nature have been given a statutory footing in the Mental Capacity Act 2005 rather than being underpinned by the inherent jurisdiction of the High Court.

The Mental Capacity Act 2005 was introduced in October 2007 and provides a clear statutory framework for decision making for people who lack capacity. A code of practice and guidance are also available.

The Mental Capacity Act 2005 also introduced

- Independent Mental Capacity Advocate – appointed as a consultee or sounding board, in relation to LA and NHS decisions affecting the welfare of incapacitated and unrepresented persons.
- Advanced directives to refuse treatment under statutory rules with clear guidelines
- A new criminal offence of ill treatment or wilful neglect of a person who lacks capacity
- Deputyship, as a successor status to Receivership, but incorporating a welfare decision-making power, as well as responsibility for managing finances and property.
- Changes to Enduring Power of Attorney, such that it will become possible for attorneys to exercise a welfare decision-making role on behalf of the person granting the power of attorney.

However, under section 127 of the Mental Health Act 1983 people who are vulnerable because of a 'mental disorder' are protected in two ways:

- It is an offence for staff at a hospital or mental nursing home to ill-treat or neglect someone who is receiving treatment for a mental disorder, whether as an in-patient or as an out-patient
- It is also an offence to ill-treat or neglect a mentally disordered person in one's care in any setting. This applies not only to paid carers, but also to relatives, friends and anyone providing care to the person.

('Mental disorder' covers mental illness, learning disability, personality disorder, and 'any other disability of the mind').

Under section 47 of the National Assistance Act 1948 a local Council has the power to seek an order from a Magistrates Court authorising removal from their homes of people by reference to the conditions they are living in. The application must be supported by a certificate from the community physician that the person is either:

- suffering from a grave chronic disease, or
- being aged, infirm or physically incapacitated, are living in insanitary conditions,

  and
- are unable to devote to themselves, and are not receiving from other persons, proper care and attention

  and
- needs to be removed in his or her own interests or to prevent harm or serious nuisance to others.

Commission for Social Care Inspection

The Commission for Social Care Inspection (CSCI) has wide powers under the Care Standards Act 2000 to investigate suspected neglect and ill treatment in residential, nursing homes, and on the part of domiciliary care providers, in order to regulate providers. Professionals, relatives or others who suspect that proper care is not being provided should contact the Commission. (see Appendix 6 for local contact details).

The Commission has the power to serve statutory notices requiring deficiencies in the care regime to be rectified and, in extreme cases, may apply to the court to cancel registration with immediate effect.

Financial abuse

The following criminal offences should be borne in mind:

Theft

Theft is the dishonest appropriation of property, intending to deprive the owner permanently (section 2 Theft Act 1969). Theft does not necessarily involve physically moving something; any purported exercise of the rights of the owner will suffice, but dishonesty does have to be proved, and it is a defence to show a reasonable belief that the owner would have consented, had he or she known (section 2).

Obtaining Property or a Pecuniary Advantage by Deception

(Theft Act 1969, Sections 15 and 16)

Fraud

Dishonestly prejudicing someone else's economic rights.

Protective measures

Guardianship under the Mental Health Act 1983

Guardianship may enable people who are mentally disordered to be protected by the exercise of one or more of three powers:

- Requiring access to the person for named professionals or others
- Requiring the person to attend outside the home for occupation, education, training or medical treatment (though note that this does not override the person's right of refusal of consent to the treatment itself)

- Requiring the person to reside at a specified place.

Guardianship is available if the person is suffering from a mental disorder 'of a nature or degree' such as to warrant guardianship. It must also be 'necessary' in the interests of the person's own welfare or for the protection of others that the other person should be received into guardianship.

Appointeeship

The Court of Protection is rarely suitable where modest sums of money are involved. Where the person's only source of income is state pension and/or benefits such as Income Support, Pension Credit or Attendance Allowance the Department for Work and Pensions (DWP) will consider appointing someone else to receive the monies (the appointee) and to use the monies for expenses such as household bills, food and personal items. The appointee does not have the authority to deal with capital or other income (eg, occupational pension) belonging to the person). Appointees can only deal with th income received from the DWP except in the case of small amounts of surplus state pension and/or benifits (capitalised savings) which can be used to meet unforseen emergencies.

Deputyship (previously called Receivership)

The role of deputy under the Act is wide enough to cover welfare decision making.

Both the court and the deputy are subject to the best interests principles set out in the Act. Deputies will be authorised to decide where a person should live, what contact s/he might have with any specified person, and to give or refuse consent to a health care treatment for the person concerned (but not to a life-sustaining treatment). Deputies are going to be allowed to restrain those in respect of whom they act, subject to conditions, but must not detain him or her.

Local authority office holders will be able to apply for deputyship, but so will ordinary carers and relatives of vulnerable adults.

When a local authority office holder acts as deputy, however, they will be doing so under the Act, and not in the discharge of their employer social services departmental functions, which could cause a conflict of interest and/or dispute about the difference between what is in the best interests of a person, versus what would be a lawful, adequate discharge of a social services function in respect of that person's statutory right to have their assessed eligible needs met.

There will be things that a deputy cannot do without authority from the court, and the Act provides that a deputy cannot displace the proper decision of a holder of a Lasting Power of Attorney, previously known as Enduring Power of Attorney.

Section 45 of the Mental Capacity Act 2005 abolished the former office of the Supreme Court as the Court of Protection and replaced it with a new court, also known as the Court of Protection, which is empowered to deal with all areas of decision-making for people who lack capacity. The new court combines the personal welfare and healthcare jurisdiction (formerly exercised by the Family Division) with the financial decision-making jurisdiction of the former Court of Protection.
The main functions of the new Court of Protection are:

- make declarations as to whether someone has the capacity to make a particular decision;
- make single one-off orders e.g. an order authorising the execution of a statutory will or an order for the sale of a house and the investment of the proceeds;
- appoint a deputy to make decisions in relation to the matters(s) in which a person lacks the capacity to make a decision;
- resolve various issue involving Lasting Powers of Attorney (LPA) or Enduring Powers of Attorney (EPA).

The court will confer on the deputy a general authority to take possession or control of the person's property and affairs and to exercise the same powers of management and investment as the person has as beneficial owner, subject to the terms and conditions set out in the order.

Since October 2007 the Court of Protection has not been authorised to issue either a Short Order nor a Direction of the Public Guardian to deal with small estates and therefore if a formal order to manage the property and affairs of someone lacking capacity is required it will be necessary to obtain an order for a court-appointed deputy.

Central Finance Team (Client Affairs) see contact details at Appendix 6.

Powers of Entry

Warrant to search and remove

Section 135 of the Mental Health Act 1983 – a social worker approved under the Mental Health Act may apply to a Magistrate for a warrant authorizing the police to enter premises where a person believed to be suffering from mental disorder is living, if there is reasonable cause to suspect that they are being ill-treated or neglected or otherwise than under proper control, or are unable to care for themselves and are alone, for the purpose of removing the person to a place of safety for purposes of assessment.

Powers of entry and inspection

Section 115 of the Mental Health Act 1983- an approved social worker may at all reasonable times on producing identification enter and inspect any premises other than a hospital in which a mentally disordered patient is living, if s/he has reasonable cause to believe that the patient is not under proper care. The approved social worker can not force entry, however, s/he can point out to any person refusing entry that a refusal would constitute an offence under section 129 (obstruction).

Police powers of entry

Police can enter premises without a warrant in a number of different situations. Examples include:

- dealing with a breach of the peace or to prevent it
- enforcing an arrest warrant
- arresting a person in connection with certain offences
- recapturing someone who has escaped from custody
- saving life or preventing serious damage to property

Court orders to protect people from violence, threats and harassment

It is an offence under the Protection from Harassment Act 1997 to harass someone (whether or not they are vulnerable), or to put him or her in fear that violence will be used against them. Perpetrators who threaten or harass more than once may be prosecuted and/or sued in the civil courts by their victims; and may have restraining orders made to prevent a recurrence.

The Family Law Act 1966 enables people who have capacity, or a Litigation Friend willing to act for them, and who are linked by a domestic or family relationship to apply for a non-molestation order, which orders one person to stop pestering, threatening or being violent to another person, or any child involved; or for an occupation order, which may order a violent person to leave the home, or part of it, and/or not to come near the home. An occupation order may also regulate rights to occupy the home. Powers of arrest can be attached to non-molestation and occupation orders.

To bring an action in the civil courts a person has to have the capacity to make an informed decision, and they have to bring the proceedings, or instruct solicitors to do this, or have a Litigation Friend to act for them – consideration with regards to taking on such a role could be given by Social Services. There is provision (under section 60 of the Family Law Act) for an application for a non-molestation or occupation order made on behalf of someone else, but unfortunately this section has not yet been brought into force.

Support for practitioners

The Public Interest Disclosure Act 1998

People have been in the past often deterred from 'whistle-blowing' about abuse or neglect by duties of confidentiality and/or fear of the consequences of speaking out.

The Public Disclosure Act seeks to protect disclosure of the following:

- A criminal offence-past, ongoing or prospective failure to meet a public obligation, a miscarriage of justice, health and safety being endangered, or risk of environmental damage

OR deliberate concealment of the above.

The Act envisages that disclosure about such malpractice will generally be made in the first instance to the person's employer, or another person or body who appears responsible for the malpractice (e.g. a relative of a resident reporting matters to a manager of a home).

The Act envisages employers establishing procedures, so that staff that have concerns about breach of practice or the law can pass on these concerns to be investigated.

Whistle-blowers are only protected against the Act if they are acting in good faith, and reasonably believe that their allegations are true. Allegations made for financial gain are not protected, even if they are true.

Staff making disclosures to people, other than their employer, are likely to be protected if:

- They reasonably believe that they will be treated detrimentally for disclosing to the employer; or they reasonably believe that the evidence will be destroyed or hidden if the employer is 'tipped off'; or the employer has been told, but has taken no appropriate action (See Chapter 8)
- Disclosure to third parties has to be a 'reasonable' step in all circumstances, including:

– whom one tells (e.g. disclosure to a statutory inspectorate in preference to the press)

– how serious the concern is

– whether it is a continuing problem

– whether the employer has a whistle blowing procedure and if so, whether the employee has followed it.

In addition, if the failure is 'exceptionally serious' (a term not defined in the Act), it may be justified for the whistle-blower to disclose to a third party in the first instance, rather than their employer. (see Chapter 8)

A disclosure made in accordance with the Act's expectations will mean that:

- No confidentiality clause in an employment contract can be used to prevent one from disclosing relevant breaches of the law or practice. This means that employers who are responsible for breaking a law, or for abuse or neglect or other malpractice cannot use confidentiality terms in employment contracts. Dismissal on grounds of disclosure within the terms of the Act is automatically unfair, and can be challenged before the Employment Tribunal. Someone who is treated detrimentally at work because of making a disclosure, which is protected by the Act, can claim compensation at the Employment Tribunal.

Support for victims: 'special measures' under the Youth and Criminal Evidence Act 1999

One of the most daunting barriers for vulnerable adults seeking the protection of the criminal courts has been court rules and conventions about the way in which accounts of witnesses and victims are presented in court.

Published by the Home Office Interdepartmental Working Group in June 1998, *Speaking up for Justice*, was enacted in the Youth and Criminal Evidence Act 1999, which is being implemented in stages. Witnesses will be treated as 'vulnerable' so far as they qualify for 'special measures' if the quality of their evidence is likely to be diminished by mental illness, learning disability or physical disability or intimidation.

Contents Part 2 Procedures and Appendices

Procedures:

Appendices:

1 The Investigation and Safeguarding Adults process

The overall aim of these procedures is to enable people who are at risk of abuse or neglect to access safety.

The Procedures in this document, along with the *Safeguarding Adults Policy* chapters 9 (Sharing information and confidentiality) and 10 (The legal aspects), are intended for use as an operational guide. While staff from all relevant agencies should be familiar with the themes in the *Safeguarding Adults Policy* document, this operational guide contains the information required to enact procedures designed to ensure the safety of people who are at risk of or experiencing abuse or neglect.

These procedures detail the following stages.

Stage	Action	Max time frame
1. Alert	Report concerns of abuse or neglect, making sure that immediate protection or medical needs are addressed.	Action required to safeguard any anyone at risk (Procedure 2 - Summary Flowchart).
2. Referral	Pass information to the relevant Southwark Social Services Duty Team for processing (see Appendix 6 for contact details).	Within the same working day.
3. Decision	The screening, consultation and information-gathering process occurs to decide whether *Safeguarding Adults* procedure is appropriate to address concerns.	By the end of the working day after the one on which the safeguarding referral was made.
4. Safeguarding assessment strategy	Through an initial strategy discussion, possibly followed by a strategy meeting, begin formulating a multi-agency plan for assessing risk and addressing any immediate protection needs. Investigation report to be prepared by allocated worker.	Within five working days.
5. Safeguarding assessment/ Investigation	Co-ordinate all information about abuse or potential risk of abuse and current risk levels. Decide the way forward including whether the issue is a single or joint investigation.	Within four weeks of the safeguarding referral.
6. Safeguarding plan	Co-ordinate the response to the outcomes of the multi-agency *Safeguarding Adults* strategy and develop a safeguarding plan.	Within four weeks of completing *Safeguarding Adults* assessment.
7. Review	Review the *Safeguarding Adults* plan.	Within six months from the first review and yearly thereafter (unless the situation changes).
Recording and Monitoring	Record and monitor the *Safeguarding Adults* plan and its outcomes in line with Southwark's recording policies and procedures.	

Stage 1. The alert (the same working day) See Procedure 2 Summary Flowchart: What to do if you have concerns about or suspect abuse.

If there is immediate danger, a medical emergency or it is suspected that a crime has been committed contact the appropriate Emergency Service without delay by calling 999.

The person alerted to or who discovers the abuse should inform their line manager without delay.

Where possible consent to make a referral should be gained from a mentally capable adult who is thought to be experiencing abuse or neglect,

- unless there are overriding public duties to act to protect others or an incapacitated adult
- or if gaining consent would put the person at further risk.

Within the same day suspicion or disclosure of abuse and neglect must be reported to the appropriate Southwark Social Services Team initially by telephone and then if necessary by fax or email (see Appendix 6 for contact details).

If the allegation or suspicion involves a regulated service such as a care home or domiciliary care agency this should also be reported to the Commission for Social Care Inspection (see Appendix 6 for local contact details).

Stage 2. Referral to the Social Services Investigating Team (the same working day)

The person taking the referral must consider and action if not already done so any emergency arrangements, which may require immediate medical or police involvement.

At the point of referral the worker taking the information must complete the Adult Protection Referral Form (AP1) ensuring they collect as much information as possible (Appendix 1 AP1 Form).

This information must then be discussed with an appropriate manager within the receiving team and moved on to Stage 3. Other agencies involved must be informed about progress unless it is unsafe and/or inappropriate to do so.

A copy of the AP1 Form must be sent to:

The Safeguarding Adults Protection Co-ordinator

Referring organisation, if safe to do so, as acknowledgement of referral.

Social Services Commissioning and Commission for Social Care Inspection if a regulated service is involved

(See Appendix 6 contact details)

Stage 3. Decision-making/screening (by the end of the working day)

Following the initial referral it may be necessary to conduct further consultation and information gathering before a manager can screen it and decide whether the safeguarding adults procedure is appropriate.

If an adult is not covered by this policy information must be given or a referral made to an appropriate service or team. This action and reasons should be recorded. Examples may include referring someone to the Hate Crime Unit who is experiencing domestic violence or to the ordinary care management team for that client group.

Where a child or young person under the age of 18 may be at risk a referral should be made to the Safeguarding Children Service (see Appendix 6 for local contact details).

If a decision is made to proceed under these Procedures move to Stage 4. The manager should record their decisions on the case notes including the level of urgency. The risk assessment summary form may help with this (see Appendix 5).

At this point in the process all immediate risks should have been minimised, however, this may not be possible if for example the individual concerned refuses help. If the person has capacity to consent the caseworker must support them with the aim of assisting them to move to a position were they feel able to protect themselves. If the person does not have capacity action may need to be taken in their 'best interest' (common law and Mental Capacity Act 2005).

If there is a 'public interest' issue such as others are at risk you may need to take action whether the person agrees or not. In such circumstances any action must be discussed with an appropriate manager and justification recorded

in writing. All actions must be carried out as sensitively as possible for the individual concerned.

In a crisis situation it may be necessary to take immediate action to protect an individual by providing increased care or an emergency placement until more permanent arrangements can be made. Under such circumstances the duty or allocated worker should record as much information about the person's needs on the case file and arrange any service by telephone, facsimile or e-mail. A full needs assessment will need to be completed within five days.

Services provided as an emergency measure are usually non-chargeable in the first instance. However such arrangements are temporary.

If there is a need to involve the Police the duty or allocated worker can call for advice and/or use the AP1 to make a referral. In order to avoid delay complete the form as fully as possible. Early consultation will enable the Police to establish whether a criminal act has been committed and give them an opportunity to determine if they need to become involved. The time scale for a police response to a non-emergency referral is two days. (See Appendix 6 for local contact details)

As a general rule the alleged perpetrator should not be contacted until there is an agreed safeguarding assessment strategy. There may be exceptions where this is part of an emergency action plan to safeguard the adult or others. For example, an employer needs to suspend a member of staff in response to an allegation.

Stage 4. Safeguarding Assessment Strategy discussions and/or if appropriate strategy meeting (five working days)

The aim of this stage is to decide how best to investigate suspicions, concerns or allegations. This may involve dividing up responsibilities for particular areas of an investigation between relevant agencies. Repeated questioning of victims and witnesses must be kept to a minimum.

Developing a strategy is often a multi-agency process involving the people appropriate to a particular situation. In more serious and complex situations the most effective way of developing a strategy may be to organise a meeting (this is referred to as a *Safeguarding Adults* strategy meeting).

On other occasions it may be necessary, and more effective, to formulate an initial strategy through telephone conversations and/or emails (this is referred to as the *Safeguarding Adults* strategy discussion).

The co-ordination of this process is designated to the investigating worker.

The timing of strategy discussions is based on the level of risk presented. Some situations require an immediate response but in all cases discussions should be completed within five days of receiving the referral.

Where possible adults with mental capacity in relation to the issue in question, who are perceived to be at risk, must be involved in strategy discussions (with appropriate support if necessary) unless prevented by issues around safety, the rights of others or if there is potential for the contamination of evidence.

During discussions and meetings information must be considered in relation to information sharing principles and if appropriate consent must be sought. A multi-agency information-sharing protocol is being developed but in the meantime please refer to *Safeguarding Adults Policy Chapter 9, Information sharing and confidentiality*.

Strategy Discussions

Often the early stages of an investigation involve a strategy discussion – this may be by telephone – The purpose of this is to:

- Inform all partner agencies of the current situation
- Assess current levels of risk
- Assess the need for immediate action
- Plan a strategy meeting if appropriate.

You must consider using the risk assessment summary tool to help measure levels of risk, justify actions and influence future decisions (see Appendix 5).

Strategy meeting

If appropriate a strategy meeting involving relevant agencies, i.e. Social Services, Police, Health, CSCI, voluntary sector and legal department must now be co-ordinated by Social Services.

Consideration must be given to others attending the meeting including the client and any representative(s). Decisions about who is invited outside the core group must be agreed by all agencies and reasons recorded.

An investigation report will need to be prepared for the strategy meeting (See guidelines on page 37).

You must also include any relevant assessments, including the Section 47 assessment of need for services and any risk assessments.

More than one strategy discussion and/or meeting may be necessary to enable the collection and sharing of information.

The purpose of a safeguarding adults strategy meeting/discussion is to:

- Ensure the safety of the vulnerable adult
- Allocate an investigating officer
- Define whether a joint investigation is necessary
- Exchange information across agencies
- Decide what action – if any – needs to be taken
- Agree next actions in the form of an adult protection plan
- Arrange a further meeting – if necessary
- Decide whether a media strategy is required.

A written record must be made of all strategy meetings and telephone discussions, using the AP2 Form (Appendix 2).

If a meeting is held the AP2 Form must be signed up to by all parties. Any concerns or disagreements regarding the plan should be recorded on the form and a copy sent to all relevant parties, if safe to do so, and the Safeguarding Adults Co-ordinator.

If an allegation is made concerning a person receiving a regulated service the Social Services Commissioning Department and the Commission for Social Care Inspection must be consulted at the earliest opportunity and invited to any meetings. They will then decide if they need to be involved.

Work undertaken and information gathered at this stage will inform the *Safeguarding Adults* Assessment/ Investigation.

Stage 5. The Safeguarding Assessment/Investigation
(within four weeks of referral)

Timescales for completing investigations depend on the severity of alleged or suspected abuse and the emotional needs of the vulnerable adult(s).

Investigation usually begins at referral; in less serious situations progress through the stages can be quick. In any event it must be initiated within 48 hours of agreeing a strategy and if possible concluded within four weeks. The investigation process aims to:

- Establish matters of fact – i.e. what has actually happened?
- Assess the vulnerable adult's needs and provide support and redress
- Decide on action to take, in relation to alleged perpetrator(s), services, its management, if they have been culpable, ineffective or negligent.

Adults that may be at risk and have mental capacity are usually first to be interviewed as part of the investigation. Their safety and confidentiality is paramount, except if information needs to be shared to protect the vital interests of others.

Adults with communication needs must be given access to appropriate support to enable them to be part of the investigation. This may be an independent interpreter, a signer, someone with specialist skills such as a speech and language therapist, psychologist or advocate. Individuals should have relevant knowledge of any requirements, culture and observances of those concerned. The person providing communication support must be briefed prior to the interview. Staff must be aware of potential conflicts that may arise when using an interpreter and ensure that they have no involvement in the case. Consideration must be given to providing information in a variety of languages and formats on a case-by-case basis. Involvement of an Independent Mental Capacity Advocate must be considered where the person lacks capacity. (see Part 1 4.6)

If staff are implicated in a case of abuse, immediate discussion must take place between all relevant agencies in order to minimise any risks.

If an investigation requires the suspension of staff member(s), the organisation's disciplinary procedures must be followed at all times. In exceptional circumstances, if considered necessary to conduct an investigation prior to informing implicated staff, a clear record must be made of who took the decision and why. An example may include risks that the person concerned may destroy or contaminate evidence.

Protection Of Vulnerable Adults (POVA) register

In a situation involving a member of staff, urgent attention must be given by the line manager, in consultation with the Safeguarding Adults Co-ordinator if necessary, as to whether the incident is likely to result in a statutory duty to refer the alleged perpetrator's name to the Secretary of State for consideration regarding placement onto the POVA register.

Keeping accurate records during the investigation

It is vital that clear and accurate records are kept of all interventions, because these may be required as evidence in court proceedings

- Ensure that information from the initial disclosure is recorded
- All records should be made contemporaneously (at the time of discussion) or as soon as is possible after any discussion
- Always use the exact words spoken where possible
- Records should show what is recorded as fact and what is opinion
- All records should be signed, dated and located
- Keep original records of discussion(s), meeting(s) or telephone conversations and any notes as these may be required as evidence later
- If the Police lead a case they may still require support from other agencies in collecting or preserving information.

Recording of information must conform to the relevant departmental or organisational procedures, policy and guidelines.

The investigation report

The format below is a guide on what to include in a report for a strategy or investigation report. It will be prepared by the delegated lead worker and presented at the meeting or at any discussion if appropriate. It must be brief, concise, factual and evidence based, even where opinions are involved. Use bullet points where possible. The report must include:

- Name, address and date of birth of the adult
- Allegations/suspicions reported – list each separately. If an allegation has been made, note who is making it. If there is a suspicion, what is the basis for it? Record dates and locations where known
- Previous related allegations or history of abuse – detail known outcomes
- A brief description of the person, including the nature of their disability/vulnerability and communication needs
- Current social situation/family network and details of services received
- Assessment of the person's capacity to consent in relation to any allegations or suspicions. Consider the Code of Practice for the Mental Capacity Act 2005 once it comes into force and until then the common law.
- Legal status (court of protection, power of attorney, Mental Health Act)
- The person's views of the situation
- Information about the person alleged to be responsible for the abuse
- A description of the investigation process and evidence gathered so far. Attach any evidence such as body maps, medical or other reports
- An evaluation of the evidence gained so far
- Your assessment of the seriousness of abuse
- Any risk assessments made
- Your recommendation for action
- Your name, organisation, team, job, qualifications, sign and date report.

The Safeguarding case conference

In many situations it may be more effective to collect findings and formulate plans through a series of telephone conversations, letters, faxes, and/or emails.

If appropriate a case conference must be called, to draw information together and formulate a Safeguarding Plan. If possible the vulnerable person must be invited and consulted as to whom he/she would like to attend. The lead worker must consult with any representatives if the person's wishes cannot be ascertained.

Carers (formal/informal) must be invited to the case conference and given a chance to contribute to the formulation of any plans unless there is good reason for not doing so. An example may be if the carer was the alleged perpetrator. If the carer is part of any plan then you may wish to invite them as they will need to sign up to it.

The lead worker convenes a case conference that is chaired by a manager.

Conferences and decisions must be recorded on an AP2 Form (Appendix 2).

A separate case conference must be held for each person abused.

If the alleged perpetrator has community care needs then a strategy meeting or case conference must be convened to look at their needs as he or she may be equally entitled to an assessment and provision arrangements that may resolve or mitigate the risks to others.

Stage 6. The Safeguarding Plan
(within four weeks of the investigation being completed)

The aim of this stage is to develop a Safeguarding Plan, where necessary, based on the findings of the investigation.

It may be appropriate to devise a plan through telephone calls and/or emails. As stated information and decisions must be recorded on an AP2 Form (Appendix 2)

At this stage of the safeguarding process a decision must be made about whether: abuse/neglect has taken place; that it did not; or that it was more likely than not that it did; or that this is still not known; and whether or not there is thought to be ongoing risk of abuse or neglect.

Where abuse has taken place, was more likely to have occurred than not, or an ongoing risk of abuse is identified, a Safeguarding Plan must be agreed with proactive steps to prevent further abuse and/or to decrease risk. Positive actions to promote recovery from abuse or neglect should be planned in.

Positive actions should also be determined in order to prevent the perpetrator from abusing and/or neglecting in the future.

If abuse has taken place active consideration in consultation, with the police and legal services, of the potential use of the law and the possible use of special measures under Achieving Best Evidence principles should ensue.

Each agency that has had a role in the case must provide a written report of that work which must be considered in relation to the Safeguarding Plan.

Adults that have been the concern of a Safeguarding Investigation should be involved in the formulation of a plan, because it is, fundamentally, a **care** plan.

The agreed Safeguarding Plan of Action will:

- **Nominate a worker** to provide a focal point for liaison and communication and ensure that the action plan is followed
- **Specify responsibilities and roles of each named agency and worker**
- **Identify clear objectives**
- If a **criminal investigation is in progress nominate an officer** who will ensure that all involved are informed of progress and outcomes
- If appropriate arrange for **monitoring, support and counselling**
- **Review the action plan** to the agreed time scale
- Propose **further dates for review** or agree no further action.

Appropriate feedback should be given to those who reported the abuse or neglect concerning the outcome of their alert.

As stated use the AP2 Form to record all meetings held under these procedures and circulate to those involved if safe to do so (Appendix 2).

Stage 7. Review Monitoring of the Safeguarding Plan (within six months of the Safeguarding Plan)

A safeguarding plan should be the outcome of an investigation that will protect the individual or individuals from further abuse.

Any change in circumstances may result in changes to the safeguarding plan.

If there are difficulties in achieving the objectives the nominated person must report back to the appropriate manager and the Safeguarding Adults Co-ordinator.

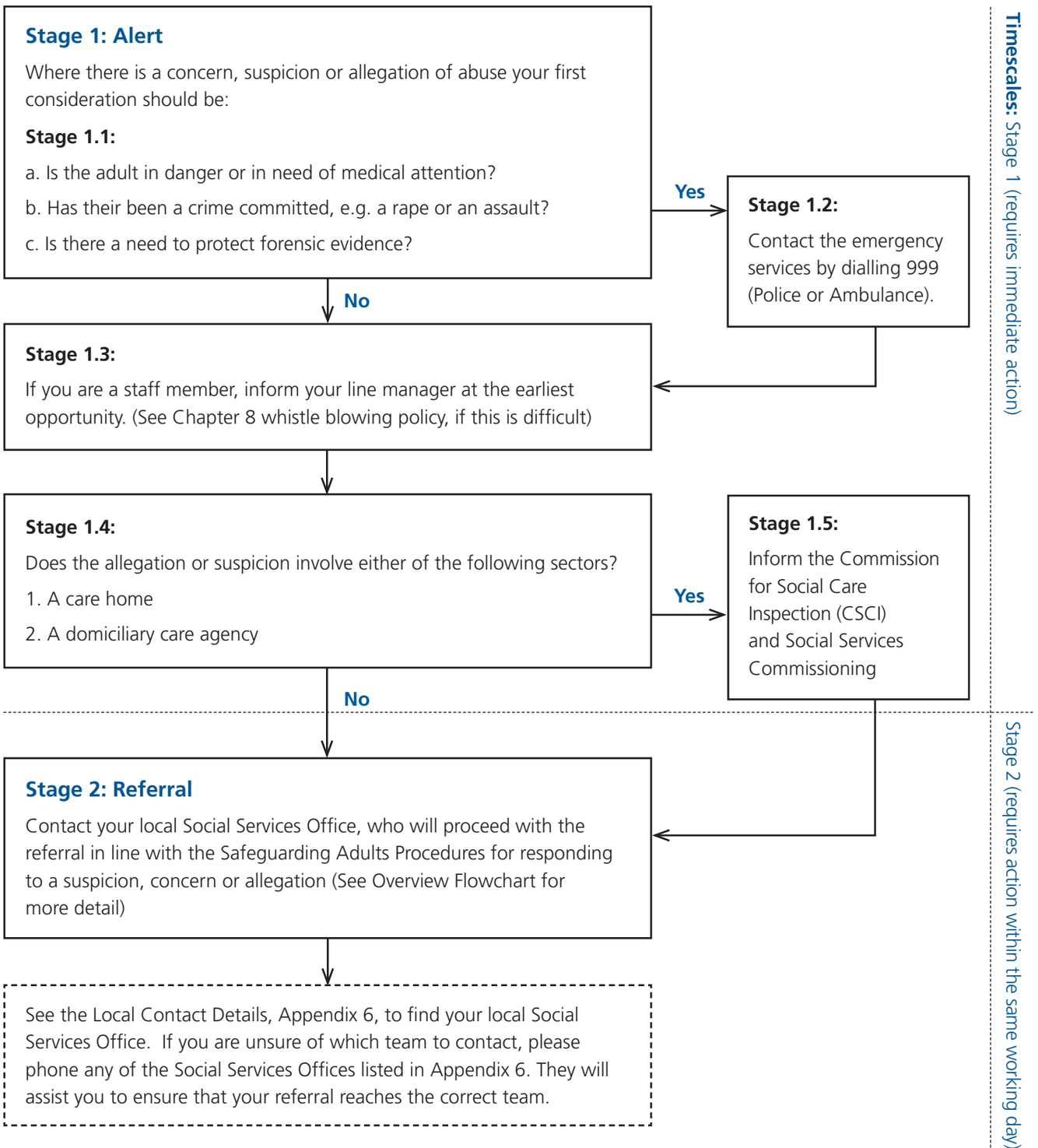
A timescale for review should be agreed when the plan is formulated but in any event this should be within six months of the Safeguarding Plan.

Following the review if all issues have been resolved you must complete an Adult Protection Outcomes Form (AP3), which will close the formal safeguarding process.
A copy must be sent to the Safeguarding Adults Co-ordinator (Appendix 3).

It is important to note that the Safeguarding Adult Protection Plan must be incorporated in to the person's care plan.

2 Summary Flowchart

What to do if you have concerns about or suspect abuse



3 Referral Procedure – Overview Flowchart

It should be noted that many of the stages described here might occur together.

For further information refer to Procedure 1 (Responding to abuse and neglect).

Stage 1: Alert (See Summary Flowchart of the referral process) • A suspicion, concern or allegations of abuse is received into a Social Services Team.	**Stage 1** requires immediate action	**Day One**
Stage 2: Referral Aims – To gather as much initial information as possible • Once a Safeguarding Referral has been made to a Social Services Team the caseworker should ensure that all immediate risks are minimised. Including involving the emergency services, if appropriate. • The worker taking the referral should inform an appropriate manager, complete an **AP1 Form**, sending send a copy to the Safeguarding Adults Coordinator. • The **AP1 Form** can also be used to refer non-emergency situations to the police (See the Safeguarding Adults Policy Chapter 5, Working with the Police), the Commission for Social Care Inspection and Social Services Adults Commissioning Unit.	**Stage 2** requires action within the same working day	
Stage 3: Decision Aims – To decide if the Safeguarding procedure is appropriate • If there is a police investigation then this takes precedence over other investigations. • If there is not enough information to make a decision, begin a process of information gathering to enable screening. • If a decision is made to proceed than move to Stage 4. • If a staff member is implicated, consideration needs to be given to the relevant agencies' disciplinary procedures.	**Stage 3** requires action by the end of the next working day following the completion of Stage 2.	**Day Two**
Stage 4: Safeguarding Assessment Strategy Aims – The investigation: To decide how best to investigate the allegation • Developing a strategy can take the form of a discussion and/or a meeting. It is usually a multi-agency process and if appropriate should involve the victim(s) and the informal carers. • The strategy may involve dividing up responsibility for different aspects of the investigation • Coordinating responsibility is designated to the investigating worker. • All discussions and meetings should be recorded on the **AP2 Form** and a copy sent to the Safeguarding Adults Coordinator.	**Stage 4** requires action within 5 working days	**Day Five**
Stage 5: Safeguarding Assessment Aims – To establish what has happened by drawing together the findings from the investigation • If appropriate this can be done through a series of reports, phone calls and/or emails. • In more complex situations the nominated worker may call a case conference, which should be chaired by an appropriate manager. • If necessary an investigation report is prepared by the nominated worker. • A record of the conference should be recorded on the **AP2 Form** and a copy sent to the Safeguarding Adults Coordinator.	**Stage 5** requires action within 4 weeks	**Week Four**
Stage 6: Safeguarding Plan Aims – To formulate a Safeguarding plan, which will protect those at risk from abuse • The nominated worker should formulate the Multi Agency Safeguarding Plan, which should be based on the findings of the investigation. This may take place as part of stage 5. • Plans must be recorded on the **AP2 Form** and a copy sent to the Safeguarding Adults Coordinator.	**Stage 6** requires action within 8 weeks of the referral.	**Week 8**
Stage 7: Review Aims – To review the Safeguarding Plan whose timescale should be agreed when it is formulated, but must be within 6 months • This may lead to further Safeguarding Plans being formulated and the completion of an **AP2 Form**. • If a decision is made that it is no longer necessary to continue under the Safeguarding Procedures then the caseworker should complete an **AP3 Form** to record the outcome and send a copy to the Safeguarding Adult Coordinator.	**Stage 7** requires action within 6 months	**Month 6**

Appendix 1

Adult Protection Referral Form (AP1) – Strictly Confidential

1. Vulnerable Adult Details

1a. Please enter the following information about the victim:

Surname: Forename: Title:

Home Address:

Postcode: Phone Number:

Date of Birth: (dd/mm/yyyy) Gender: ☐ Male ☐ Female

Religion: ☐ Baptist ☐ Buddhist ☐ Church of England ☐ Hindu

☐ Jewish ☐ Methodist ☐ Muslim ☐ Roman Catholic ☐ Sikh

☐ None ☐ Other – Please specify

1b. Vulnerable Adult Client Group:

☐ Physical Disability ☐ Learning Disability ☐ Learning & Physical ☐ Mental & Physical ☐ Neurological

☐ Mental Disability ☐ Chronic Disease ☐ Elderly Frail ☐ Unknown ☐ HIV/Aids Services

☐ Substance Misuse ☐ Other (If yes, please enter details

1c. Vulnerable Adult Ethnicity:

☐ White British ☐ Black African ☐ Mixed White and Black Caribbean ☐ White Irish

☐ Other Black ☐ Mixed White and Black African ☐ Other White ☐ Indian

☐ Mixed White and Asian ☐ Chinese ☐ Pakistani

☐ Mixed White and Chinese ☐ Other ethnic group ☐ Bangladeshi

☐ Other Mixed background ☐ Black Caribbean ☐ Other Asian

1d. Ref Numbers (CF and Police CAD):

CareFirst Reference:

Police Reference (CAD) – Where Applicable

1e. Is the client known to services?

☐ Yes ☐ No If Yes, please provide details:

1f. Is the person a Southwark Client?

☐ Yes ☐ No If No, please provide details:

1g. Capacity:

Is the Vulnerable Adult believed to have capacity in relation to the allegation of abuse?

☐ Yes ☐ No Fluctuating:

If yes, did they agree to the investigation proceeding? ☐ Yes ☐ No

If yes, did they also agree to participate in the investigation? ☐ Yes ☐ No

If they did not agree to participate in the investigation, please describe why below:

1h. Consent and Communication:

Has the vulnerable adult given their consent for information relating to this case to be shared with other agencies? **(Consider getting signed consent)** ☐ Yes ☐ No

If the vulnerable adult does not give consent for an investigation, is there a case for overriding their decision? **(Best Interest/Public Interest)** ☐ Yes ☐ No

If yes, please provide the details here:

Does the vulnerable adult have any particular communication needs? ☐ Yes ☐ No

If yes, please provide the details here:

2. Information in relation to the allegation, suspicion or concern.

2a. Brief description of allegation, suspicion or concern:

2b. Type of abuse:

Does the allegation concern multiple types of abuse? ☐ Yes ☐ No

If yes, please tick the relevant types of abuse below. Otherwise, please tick one of the boxes.

☐ Discriminatory ☐ Psychological ☐ Sexual ☐ Financial ☐ Physical

☐ Institutional ☐ Neglect and Acts of Omission

2c. Dates and times of incident

On what date did the alleged incident occur? (dd/mm/yyyy)

At what time did the alleged incident occur? (hhhh:mm) 24 Hour Clock.

2d. Location – where did the abuse occur?

☐ Public Place ☐ Vulnerable Adult's Home ☐ Sheltered Accommodation:

☐ Supported Accommodation ☐ Vulnerable Adult's Parent's Home

☐ Alleged Perpetrator's Own Home ☐ College/Adult Education/Work Place

☐ Adult Placement Scheme ☐ Day Centre/Service: ☐ General Hospital:

☐ Acute Hospital ☐ Specialist Hospital ☐ Independent Hospital

☐ Nursing Care Home ☐ Residential Care Home

Other (Please specify in the space provided)

If Sheltered Accommodation, is the property regulated by Supporting People? ☐ Yes ☐ No

2e. Location address:

Please enter the address, where the incident of alleged abuse occurred:

2f – Source of referral:

This question refers to the individual(s) or institution(s) who made the original complaint, and who (might) then have informed the Social Services about the alleged incident of abuse:

☐ Main Family Carer ☐ Friend ☐ Other Family Members/Relatives and in-laws ☐ Other Service User

☐ Paid carer ☐ Alleged Abuse ☐ Member of Public ☐ Formal Advocate ☐ Police

☐ GP ☐ Volunteer ☐ Social Services ☐ Service Provider: ☐ CSCI

☐ Healthcare Commission ☐ Independent Healthcare Provider (Non-NHS)

☐ Specialist/Community Hospital ☐ General Hospital: ☐ Acute Hospital, including A&E

☐ Vulnerable Adults Themselves ☐ Counselling/Therapy ☐ Prison/Probation ☐ Complaints

☐ PCT ☐ Domestic Violence Unit ☐ Voluntary Agency ☐ Neighbour:

☐ Anonymous ☐ Other (Please note below)

2g. Injuries:

If the alleged abuse or crime led to an injury, please specify them here (and please complete the body chart)

2h – Witness / Witnesses:

Please enter the details of anyone who witnessed the alleged incident of abuse – and please use a separate sheet where necessary to enter further details:

Surname: Forename: Title:

Home Address:

Postcode: Phone Number:

Date of Birth: (dd/mm/yyyy) Gender: ☐ Male ☐ Female

3. Information about the alleged perpetrator

3a. Bio-demographic information about the alleged perpetrator

Surname: Forename: Title:

Home Address:

Postcode: Phone Number:

Date of Birth: (dd/mm/yyyy) Gender: ☐ Male ☐ Female

If known, please tick the relevant age group for the alleged perpetrator:

☐ <18 ☐ 18 – 29 ☐ 30 – 39 ☐ 40 – 49 ☐ 50 – 59

☐ 60 – 69 ☐ 70 – 79 ☐ 80+

Is the perpetrator a service user? ☐ Yes ☐ No

3b. Relationship to victim – paid or unpaid?

Does the alleged incident relate to a member of staff (Paid or Unpaid)? ☐ Yes ☐ No

3c. Type of relationship:

☐ Partner ☐ Main Family Carer ☐ Friend ☐ Stranger ☐ Other Service User

☐ Other Family Member (Including Relatives or in-laws) ☐ Neighbour ☐ Not Known

☐ Volunteer/Befriender ☐ Other Professional (Nurse, GP, District Nurse, Social Worker etc)

☐ Institution (including health setting and residential/nursing care and Domiciliary Care Agency)

3d. Does the alleged perpetrator live with the victim?

Does the alleged perpetrator live with the vulnerable adult? ☐ Yes ☐ No

If Yes, does the alleged perpetrator care for the vulnerable adult: ☐ Yes ☐ No

If Yes, is the perpetrator/carer employed via: ☐ An Agency ☐ Direct Payments

☐ Independent Living Fund ☐ Arranged Privately ☐ Other, please specify below

3e. Service Provider Information

Please enter the following details if the alleged abuse concerns an employee or volunteer of a Service Provider:

Agency or Company Name:

Contact Details – Surname: Forename: Title:

Address:

Postcode: Phone Number:

4. Referral History and current referral

4a. Previous referrals:

Have there been referrals involving this vulnerable adult in the past? ☐ Yes ☐ No

If yes, did they agree to be involved with those investigations? ☐ Yes ☐ No

4b. Has a referral been received about the alleged perpetrator/Service Provider before?

Has a referral been made about this alleged perpetrator before? ☐ Yes ☐ No ☐ Unknown

Has a referral been made about this Service Provider before? ☐ Yes ☐ No ☐ Unknown

4c. Has a decision been made to proceed with the investigation?

Do you (the person making the referral) intend to proceed with the referral process? ☐ Yes ☐ No

If not, can you describe why?

5. Information about the person completing this form and the referring team:

Team/Locality

Surname: Forename: Title:

Team Location/Address:

Postcode: Contact Phone Number:

Signature: Date:

Manager/Supervisor name: Signature Date

Once completed this form should be forwarded to the Safeguarding Adults Service by mail, fax, or e-mail to:

2nd Floor, Mabel Goldwin House, 49 Grange Walk, London, SE1 3DY. Tel: 020 7525 1754, Fax: 020 7525 1711

E-mail: SafeguardingAdultsCoordinator@Southwark.gov.uk

A copy of the form should (1) be kept in the client's file, and if it is safe to do so (2) a copy should also be forwarded to the source, as an acknowledgement of the referral. This form can also be used to make a referral to Southwark Police, Community Support Unit, based at Walworth Police Station and can be faxed to them on 020 7232 6269. The timescale for a response from the Police is 48 hours.

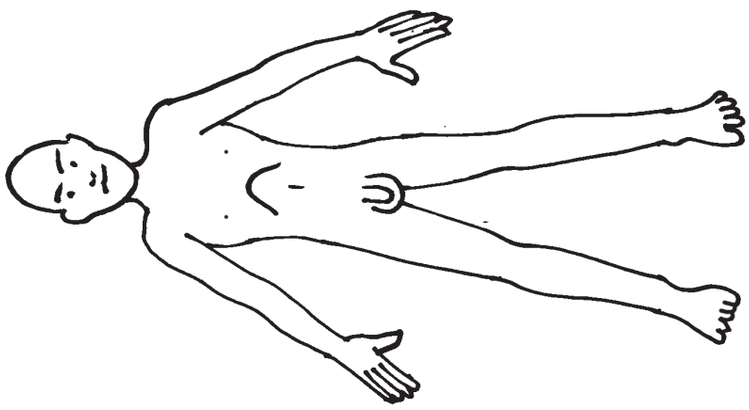
Body map

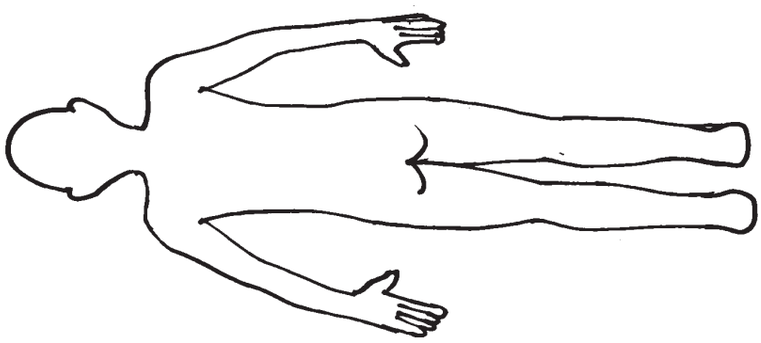
Please mark clearly on the appropriate body map all of the injuries observed.

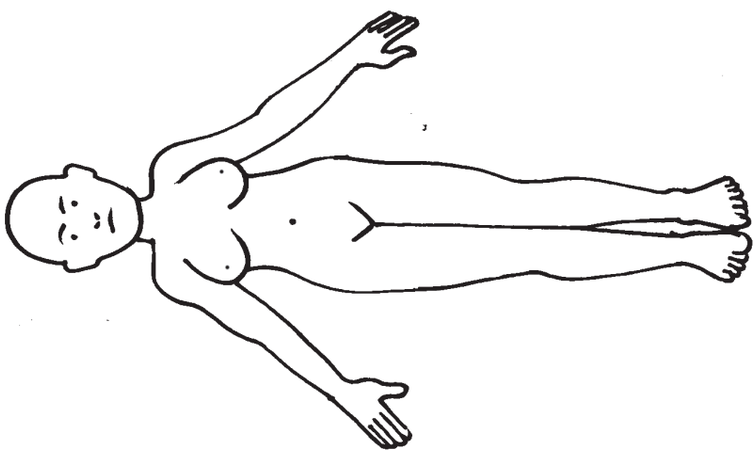
Name of service user

Name of person completing form

Date







Appendix 2

Adult Protection Plan Form (AP2) – Strictly Confidential

Record of Safeguarding Adults Meetings/Discussions and Plans

1. General details

1a. Date of initial AP1 completion

Date (dd/mm/yyyy):

Guidance - Please refer to **Section 5** of the **initial AP1**

1b. Conference details

Date (dd/mm/yyyy): Venue: Time:

Chair: Minute Taker:

2. Vulnerable Adult Details

2a. General details about the Vulnerable Adult:

Surname: Forename: Title:

Home Address:

Postcode: Phone Number:

Date of Birth: (dd/mm/yyyy) Gender: ☐ Male ☐ Female

2b. Current details about the Vulnerable Adult:

Does the Vulnerable Adult have **capacity** in relation to the incident:

☐ Yes ☐ No ☐ Fluctuating ☐ Other

If **other**, please enter further details here:

Does the Vulnerable Adult have a **disability**: ☐ Yes ☐ No ☐ Not Known

If **yes**, please enter details of the disability:

What is the Vulnerable Adult's **legal status**?

Is the Vulnerable Adult currently receiving **services/support**? ☐ Yes ☐ No

If **yes**, please enter details of the services/support:

2c. Background Information:

Please enter any relevant information in relation to:
Vulnerable Adult's communication needs:

Vulnerable Adult's cultural or religious background:

2d. Vulnerable Adult's GP:

Who is the Vulnerable Adult's GP?

GP/Practice Address:

Postcode: Phone Number: Fax Number:

3. Household and family details

3a. Please describe the composition of the Vulnerable Adult's household:

3b. List any significant relationships to the Vulnerable Adult:

Name	DOB	Address	Relationship to the Vulnerable Adult

4. Further conference details

4a. Who attended the conference (Please attach any reports):

Name	Title	Agency	Report Provided
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

4b. Invited but did not attend and provided apologies:

Name	Title	Agency

4c. Invited but did not attend and did not provide apologies:

Name	Title	Agency

5. Aims/Purpose of the meeting

Please describe the aims of the meeting:

Guidance:

Please note that the Chair should place the meeting within the context of the Safeguarding Adults Policy and state the aims i.e. If it is a strategy meeting the aim would be to decide how to investigate, if it is an assessment meeting the aim would be to draw all the evidence together and decide if an allegation has been substantiated or not. At the end of either of these meetings a plan should be agreed and recorded.

6. Circumstances leading to the allegation (background)

7. Allegations, suspicions or concerns

Please enter the details of the alleged incident(s) below

Guidance:

Please use additional sheets if necessary. Any separate sheets should be **attached** to the AP2 form when being forwarded to the Safeguarding Adults Service, and when being stored with your own case records.

Item:	Who **first made** the allegation, or **first became** suspicious or concerned?	What is the **basis** of the allegation, suspicion or concern?	What **evidence** supports the allegation, suspicion or concern?	Date of the alleged incident(s) – dd/mm/yyyy:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

8. Capacity

If the client has capacity, do they want to involve the police? ☐ Yes ☐ No

Guidance:

If the Vulnerable Adult has capacity and chooses not to involve the police or have allegations investigated a decision as to whether to override this will need to be made. This may be necessary if a serious crime has been committed or others are at risk.

If the person is not able to decide due to capacity issues, a decision will need to be taken in their best interest.

Record the reasons for all decisions:

9. Relevant Information

9a. Social Services:

Guidance:

If known, please enter information for each of the services listed, and please attach further information as appropriate, which could include community care assessments, statements or reports.

9b. Police:

9c. Health:

9d. Other (Including Independent and Voluntary Sector):

10. Discussion

Please provide a brief record of the discussion:

Guidance:

Use bullet points where possible.

11. Risk Assessment

Please outline the risks:

Please list the details of each risk below:

Item:	Risk:	Basis for the risk:	Date (dd/mm/yyyy):	Person responsible and or agency:
1.				
2.				
3.				
4.				
5.				

12. Summary details

Chair's summary (To include the objectives of any plans):

Guidance – Strategy Meeting:
If this form is being used to record a Strategy Meeting then the chair must decide what action is to be taken – plan how the Safeguarding assessment/investigation should be carried out. This may involve dividing up various aspects of the investigation between relevant parties, including those who will interview the subject.

Guidance – Safeguarding Case Conference:
If this form is being used to record a Safeguarding Case Conference a decision must be made about whether the allegation has been (1) **substantiated**, (2) **partially substantiated** (3) **not substantiated**, (4) **not determined/inconclusive**, or found to have been (5) **more likely than not to have occurred**.

Guidance – Case closure:
If the Safeguarding Case Conference finds that the allegation is (2) **not substantiated** or that the case is not being continued for some other reason, please complete the **AP3** form.

13. Safeguarding Plan

Guidance:

List separately all decisions/actions recommended, their timescale, and the named person/agency responsible.

Item:	Safeguarding Plan	Date (dd/mm/yyyy)	Person responsible and or agency
1.			
2.			
3.			
4.			
5.			

14. Next meeting

Date and time of follow up meeting

If known, the venue of the next meeting:

15. Signatures

Print Name	Signature	Title	Agency

16. Record of the meeting sent to the following (only send if safe to do so)

Name	Title	Agency

17. Name of chair/manager/supervisor	Signature	Date

Copies of all completed forms should be sent to the Safeguarding Adults Coordinator at:

Safeguarding Adults Service, 2nd Floor, Mabel Goldwin House, 49 Grange Walk, London, SE1 3DY. Tel: 020 7525 1754, Fax: 020 7525 1711 E-mail: Adult Protection Coordinator – SafeguardingAdultsCoordinator@Southwark.gov.uk

A copy of the form should also be kept in the vulnerable adult's file

Appendix 3

Adult Protection Outcomes Form (AP3) – Strictly Confidential

1. General details

1a. Date of initial AP1 completion

Date (dd/mm/yyyy):

Guidance - Please refer to **Section 5** of the **initial AP1**

1b. Please enter the following information about the victim

Surname: Forename: Title:

Home Address:

Postcode: Phone Number:

Date of Birth: (dd/mm/yyyy) Gender: ☐ Male ☐ Female

Care First Ref No:

2. Organisations involved in the investigation

☐ Police ☐ CSCI ☐ Healthcare Commission

☐ Other Local Authority ☐ Hospital Non-Acute ☐ Hospital Acute, including A & E ☐ Housing:

☐ Social Services ☐ Mental Health Services ☐ Nursing Home

☐ Residential Home ☐ Domiciliary/Homecare Agency ☐ Court of Protection ☐ Provider Agency

☐ Other (Please specify):

3. Case Conclusion

Item	Conclusion:	Definition:
1.	Substantiated	All of the allegations of abuse are substantiated on the balance of probabilities
2.	Partly Substantiated	This would apply to cases where it has been possible to substantiate some but not all of the allegations made on the balance of probabilities. For example *'it was possible to substantiate the physical abuse but it was not possible to substantiate the allegation of financial abuse'*.
3.	Not Substantiated	It is not possible to substantiate on the balance of probabilities any of the allegations of abuse made.
4.	Not Determined/ Inconclusive:	This would apply to cases where it is not possible to record an outcome against any of the other categories.
5.	More Likely than not to have occurred:	

4. Protection Plan Offered

Has a Protection Plan been offered: ☐ Yes ☐ No

If a Protection Plan has been offered, and if the Vulnerable Adult has capacity in relation to this offer, has the Vulnerable Adult accepted the plan? ☐ Yes ☐ No

5. Outcomes for the Alleged Victim

Guidance: Please tick against as many item numbers as apply below

Item:	Conclusion:	Definition:
1.	Action under Mental Health Act:	
2.	Advocacy / (IMCA appointed):	This should be related to an aim of challenging abuse faced by vulnerable adult and/or increasing independence, well being and choice of the vulnerable adult.
3.	Civil Action (in own name or via Litigation Friend):	This would include but not be limited to an application for a Restraining Order and Suing for Damages.
4.	Community Care Assessment and Services:	This may include a Carers Assessment.
5.	Counselling/Support:	This should be related to an aim of challenging abuse faced by vulnerable adult and/or increasing independence, well being and choice of the vulnerable adult.
6.	Court of Protection:	To change a Continuing or Enduring Power of Attorney.
7.	Declaratory Relief / Deputyship:	
8.	Guardianship:	
9.	Increased Monitoring:	This should include all monitoring of situations that may be potentially abusive. The monitoring should have a specific purpose i.e. to minimise risk of further abuse and/or to raise the alert if further abuse occurs. Organisations and individuals involved in such monitoring should be aware of the role they are undertaking. The monitoring should be for a specific time period and should be measured at the end of that time period to assess whether the initial purpose has been met.
10.	Management of Access to Alleged Perpetrator:	Restriction or Management of Access of Vulnerable Adult to Alleged Perpetrator.
11.	Management of Access to Finances:	Management of Vulnerable Adults access to their own finances.
12.	Moved to Increased / Different Care:	This would include any move to increase the level of care i.e. a move into supported accommodation, extra care sheltered housing, residential or nursing care and respite care. It would also include a move from one care establishment to another offering the same care i.e. a move from one nursing home to another.
13.	No Further Action:	
14.	Other (Please specify):	
15.	Referred to complaints procedure:	
16.	Removed from Property/Service:	Vulnerable Adult removed from property or service.

6. Outcomes for the Alleged Perpetrator

Guidance: Please tick against as many item numbers as apply below

Item:	Conclusion:	Definition:
1.	Action by Commissioning/Placing Authority	
2.	Action by CSCI	Any action undertaken by CSCI following an allegation of abuse. This would include inspection activity, regulatory activity and enforcement action.
3.	Action by the Healthcare Commission	Any action undertaken by the Healthcare Commission following an allegation of abuse. This would include inspection activity, regulatory activity and enforcement action.
4.	Action under the Mental Capacity Act 2005 for alleged perpetrator of abuse	
5.	Alleged Perpetrator referred to POVA List	This would be by the employer or CSCI.
6.	Case Review	
7.	Community Care Assessment and Services for the alleged perpetrator	
8.	Continued Monitoring of Alleged Perpetrator	This must have the specific purpose of reducing the opportunity to abuse and/or raising an alert if further abuse occurs. Organisations and individuals involved in such monitoring must be aware of the role they are undertaking. The monitoring must be for a specific time period and should be measured at the end of the time period to assess whether initial purpose has been met.
9.	Counselling/Support:	
10.	Criminal Prosecution	This should include all cases where a decision to prosecute has been taken by the Crown Prosecution Service.
11.	Disciplinary Action against Alleged Perpetrator	This can only be carried out by an employer.
12.	Management Action – supervision, training, etc;	
13.	Management of access to the Vulnerable Adult by the Perpetrator	
14.	No Further Action	
15.	Not known	
16.	Other	
17.	Police Action	This includes all action taken by the police following a referral. It may include but not be limited to monitoring of situation/offender, interviewing alleged perpetrator either under caution or not, and advice on crime prevention.
18.	Referral to Registration Body	This would include but not be limited to the General Social Care Council, Nursing and Midwifery Council, British Medical Association.
19.	Removal of Alleged Perpetrator from property or Service	

7. Date of Review

Date of Final Review (dd/mm/yyyy):	Not Applicable:	Date Case Closed (dd/mm/yyyy): **Guidance**: This refers to the incident/allegation.	Number of case conferences:	Number of reviews	Number of Strategy Meetings:

8. Informed of the Decision and Outcome (If safe to do so)

(All relevant people should be informed that the issues have been addressed). NB Please put N/A if Not Applicable.

Service User	Date (dd/mm/yyyy):	By Whom:
Carer	Date (dd/mm/yyyy):	By Whom:
Staff Member	Date (dd/mm/yyyy):	By Whom:
Referrer	Date (dd/mm/yyyy):	By Whom:
Perpetrator	Date (dd/mm/yyyy):	By Whom:

9. Further Outcome Details

9a. Service Changes:

Have any changes been made to the way in which services are run as a result of this inquiry e.g. changes in policies or procedures, changes in staffing?

Yes No:

If Yes, please describe the Service Change below:

9b. Re-occurrence:

In your opinion, is there a need to take any further action to reduce the possibility of what has happened occurring again in the future?

10. Details of Person Completing Form

Name:	Date (dd/mm/yyyy):
Designation:	Office Location:
Team/Locality:	Contact Telephone Number:
Team Manager/Supervising Officer:	Name:
Date (dd/mm/yyyy):	Signature:

Please return this form to: **Safeguarding Adults Service**, 2nd Floor, Mabel Goldwin House, 49 Grange Walk, London, SE1 3DY.
Tel: 020 7525 1754, Fax: 020 7525 1711 E-mail: Adult Protection Coordinator – SafeguardingAdultsCoordinator@Southwark.gov.uk
A copy of the form should also be kept in the vulnerable adult's file.

Appendix 4

Summary of risk form for adults living in residential and community settings

To be shared with line manager, Safeguarding Adults Co-ordinator and CSCI

Client's name: **Address:**

Date:

Potential Danger	Background Factors that Increase Risk (A)	Current events That increase Risk (B)	Elements That Decrease Risk (C)	Likelihood danger of Occurring (D)	Potential Consequences If danger Occurred (E)	Overall Risk Score (F)

Input required to reduce level of risk. (Safeguarding Adult Plan)

The form should be completed from left to right starting with the 'potential danger' box, which should clearly state any suspicion, concern or allegation.

Boxes A, B and C should contain written information based on suspicions, concerns or allegations.

Boxes D and E should contain a number between 1 and 3 to indicate the level of risk. 1 indicates low risk while 3 suggests it is high. The numbers are then multiplied to give a final score, which is meant to represent the level overall level of risk. The greater the score the higher the risk.

Box F is used to record the final score.

Appendix 5

Guidelines for Completing the Summary of Risk Form

An individual risk assessment should be precise, specific, timely, continually reviewed and communicated to all relevant people. Good risk assessment will support and provide evidence for decision-making but may also need to be used in any court proceedings. In relation to safeguarding adults from abuse, risk should be assessed and recorded at all stages of the referral process including the:

- **Alert**
- **Referral**
- **Decision**
- **Assessment strategy**
- **Assessment**
- **Plan**
- **Review.**

The level of risk needs to be made clear at the strategy meeting stage to ensure all decisions are based on up-to-date information.

Depending on the situation it may not always be necessary to assess and record the risks using the Summary of Risk form, but it may be helpful when there are multiple risks and in complex situations. If you do not use this form all risks should be recorded in the case notes and, if appropriate, in any safeguarding assessments and reports. Mixing the safeguarding assessment of risk with the ongoing assessment of need is likely to make them difficult to unravel at a later date; it is therefore essential to provide a separately titled summary of risks.

Below is an example of how the Summary of Risk form should be completed for a care home resident.

Potential danger	**Background factors that increase risk (A)**	**Current events that increase risk (B)**	**Elements that decrease risk (C)**	**Likelihood danger of occurring (D)**	**Potential consequence if danger occurred (E)**	**Overall risk (F) score**
Dehydration, pressure sores due to neglect and/or failure to act.	New home manager. High turnover of staff. High proportion of agency staff.	Large numbers of people with high levels of need. Manager yet to establish her/himself	Daughter visits three times weekly	3	3	9

Input required to reduce the level of risk (Safeguarding Adults Plan)

1. Review care plan at the home against concerns and client's needs.
2. Introduce fluid monitoring chart.
3. Assess for any pressure-relieving equipment.
4. Introduce a system for monitoring pressure areas.
5. Consider staff-to-client ratios.
6. Consider levels of activity or inactivity.

Inform Social Services Commissioning, CSCI and Care Home Support Team of any concerns.

(A) Consider triggers, i.e. weak or oppressive management, inadequate supervision, closed communication.

(B) Consider inadequate staffing, poor management, staff relations and service user behaviour patterns.

(C) Consider elements that decrease the likelihood of abuse, such as family input (unless family are implicated).

(D) Enter 3 if there is a high likelihood, 2 if there is a likelihood and 1 if there is a low likelihood.

(E) Enter 3 if the consequence would result in a high level of need, 2 if the consequence would result in a moderate level of need and 1 if it would result in a low level of need

(F) Multiply D and E. High scores indicate high-risk situation, low scores represent a current low risk.

Appendix 6

Key contacts

Customer Service Centre – if your enquiry relates to an **older person, an adult with a learning, sensory and or physical disability** and you do not know where to report your concerns your first point of contact should be to the Customer Service Centre – **Adults: 0845 600 1287**

The team will take initial details and refer you to the most appropriate team.

If your enquiry relates to **an adult experiencing mental ill heath** then you will need to contact the relevant Community Mental Health Team. If you do not know where this is then you should call the main telephone number for the Maudsley Hospital who will take initial details and refer to the relevant team – **Maudsley Hospital – 020 7703 6663**

If you do know which team to contact please see below for information

Name	Address	Telephone	Fax
1. Services for Older People			
Bermondsey & Rotherhithe Locality	3rd Floor Woodmill Building, Neckinger, London SE16 3QN	020 7525 3324	020 7525 3478
Borough & Walworth Locality	3rd Floor Woodmill Building, Neckinger, London SE16 3QN	020 7525 3324	020 7525 3478
Camberwell & Peckham Locality	4 Heaton Road, Peckham, SE15 3TH	020 7525 4600	020 7525 4606
Dulwich Locality	4 Heaton Road, Peckham, SE15 3TH	020 7525 4600	020 7525 4606
2. Older Persons Mental Health			
North	The Gate House, Ann Moss Way, Rotherhithe, SE16 2TS	020 3288 9900	020 3228 9925
South	Holmhurst, 46 Half Moon Lane, Herne Hill, SE24 9HU	020 3228 6920	020 3228 6933
3. Hospital Teams			
Hospital Discharge & Intermediate Care Team (North)	St Thomas' Hospital, Lambeth Palace Rd, Ground Floor, Block 5 South Wing, London SE1 7EH	020 7188 6199	020 7188 6196
Hospital Discharge & Intermediate Care Team (South)	Ground Floor, Jennie Lee House, Kings College Hospital, Denmark Hill, London SE5 9RS	020 3299 6276	020 3299 6348
4. Services for Adults			
Learning Disability Team	Lyon House, 160 – 166 Borough High St, SE1 1LB	020 7525 2333	020 7525 2150
Sensory & Physical Disability Team (North)	1st Floor Woodmill Building, Neckinger, London, SE16 3QN	020 7525 3962	020 7525 2123
Sensory & Physical Disability Team (South)	1st Floor, Dulwich Hospital, East Dulwich Grove, London, SE22 8PT	020 7525 3968	020 8693 5483
Substances Misuse Team	Maudsley Hospital, Lower Floor, Main Building, Denmark Hill, London, SE5 8AZ	020 3228 2400	020 3228 2959

Name	Address	Telephone	Fax
5. Adult Mental Health			
High Support Rehabilitation Team	Maudsely Hospital Site, Demark Hill, London SE5 8AZ	020 3228 7140	020 3228 7150
North East Locality	Chaucer Community Resource Centre, 13 Ann Moss Way, Lower Rd, SE16 2TH	020 3228 9800	020 3228 9850
North West Locality	27 – 29 Camberwell Rd, London SE5 0EZ	020 7525 2751	020 7525 2773
Southwark Forensic Outreach Team	Community Treatment Centre, Maudsley Hospital Site, SE5 8BB	020 3228 2327	020 3228 7150
St. Giles Locality	Douglas Bennett House, 12 Windsor Walk, Maudsley Hospital, SE5 8BB	020 3228 1800	020 3228 1845
START Team (Homeless Outreach)	Masters House, Dugard Way, Off Renfrew Rd, London SE11 4TH	020 7378 6383	020 7378 6870
STEP Team (Early Intervention in Psychosis)	First Floor, 106 Weston Street, London SE1 3QB	020 3228 2767	020 3228 3825
6. Out of Hours Team			
Out of Hours Team Weekdays: 5pm – 9am Weekends & Bank Holidays: 24 Hours	SELDOC Dulwich Hospital, East Dulwich Grove, London SE22 8PT	020 8693 9066	Phone First
7. Children's Services			
Children's Services	Accessed via the Customer Service Centre	0845 600 1286	
8. Other Useful Contacts			
Adult Social Services Commissioning Unit	3rd Floor, Woodmill Building, Neckinger, London SE16 3QN	020 7525 3813	020 7525 3894
Central Finance Team	4th Floor, Mabel Goldwin House, 49 Grange Walk, London SE1 3DY	020 7525 3981	
Commission for Social Care Inspection	46 Loman Street, London SE1 0EH	0845 015 0120	
Freedom of Information Officer for SSD & PCT	Ground Floor, Woodmill Building, Neckinger, London SE16 3QN	020 7525 3697	020 7525 3955
Guys & St Thomas' Hospital Foundation Trust	St Thomas' Hospital, Lambeth Palace Rd, London SE1 7EH	020 7188 7188	
Kings College Hospital Trust	Denmark Hill, London SE5 9RS	020 7737 4000	
Social Services Commissioning Unit for People with Learning Disabilities	1st Floor, Woodmill Building, Neckinger, London SE16 3QN	020 7525 3213	
Social Services Headquarters	Mabel Goldwin House, 49 Grange Walk, London SE1 3DY	020 7525 3838	

Name	Address	Telephone	Fax
Southwark Council Communications Team	Southwark Town Hall, Peckham Road, London SE5 8UB	020 7525 7308	020 7525 7310
South London and Maudsley NHS Foundation Trust	The Maudsley Hospital, Denmark Hill, London	0800 731 2864	
Southwark Police Community Support Unit	Walworth Police Station, 12 – 28 Manor Place, London SE17 3LR	020 7232 6160	020 7232 6276
9. Supporting Organisations			
Action on Elder Abuse	Astral House, 1268 London Rd, SW16 4ER	020 8765 7000 Help Line 0808 808 8141	020 8679 4074
Cambridge House Advocacy and IMCA Services	131 Camberwell Road, London SE5 0HF	020 7703 5025	020 7703 2903
Criminal Injuries Compensation Authority	Tay House, 300 Bath Street, Glasgow, G2 4JR	0800 358 3601	
Public Concern at work	Helpline	020 7404 6609	020 7404 6576
Southwark Carers	131 Camberwell Road, London SE5 0HF	020 7708 4497	020 7708 4877
The Carersline	Helpline	0808 808 7777	

10. Safeguarding Adults Service, 2nd Floor, Mabel Goldwin House, 49 Grange Walk, London, SE1 3DY.
Tel: 020 7525 1754, Fax: 020 7525 1711 E-mail: Adult Protection Coordinator – SafeguardingAdultsCoordinator@Southwark.gov.uk

Appendix 7

Inter-authority investigations

Association of Directors of Social Services (ADSS) Protocol for Inter-authority Investigations of Safeguarding Adults Referrals

This agreement was ratified by the ADSS on 20 February 2004 and is intended for adoption by all Local Authorities and Adult Protection Committees/Safeguarding Adults Partnerships.

1. Introduction

These arrangements recognise the increased risk to vulnerable adults whose care arrangements are complicated by cross-boundary considerations. These may arise, for example, where funding/commissioning responsibility lies with one authority and where concerns about potential abuse and/or exploitation subsequently arise in another. This would apply where the individual lives or otherwise receives services in another local authority area.

2. Aims

This protocol aims to clarify the responsibilities and actions to be taken by local authorities with respect to people who live in one area, but for whom some responsibility remains with the area from which they originated.

This protocol should be read in conjunction with Section 3.8 of *No Secrets* (DH, 2000) and LAC (93) 7 *Ordinary Residence*, which identifies these responsibilities in terms of:

- The authority where the abuse occurred in respect of the monitoring and review of services and overall responsibility for adult protection
- The registering body in fulfilling its regulatory function with regard to regulated establishments
- The placing authority's continuing duty of care to the abused person.

3. Principles

The authority where the abuse occurs will have overall responsibility for co-ordinating the adult protection arrangements (and, for the purposes of this protocol, be referred to as the host authority).

The placing authority (i.e. the authority with funding/commissioning responsibility) will have a continuing duty of care to the vulnerable adult.

The placing authority should ensure that the provider, in service specifications, has arrangements in place for protecting vulnerable adults and for managing concerns, which in turn link with local policy and procedures set out by the host authority.

The placing authority will provide any necessary support and information to the host authority in order for a prompt and thorough investigation to take place.

The host authority will make provision in service contracts, which refer to this protocol, outlining the responsibilities of the provider to notify the host authority of any adult protection concern.

4. Responsibilities of host authorities

4.1 The authority where the abuse occurred should always take the initial lead on 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.

4.2 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.

4.3 It is the responsibility of the host authority to co-ordinate any investigation of institutional abuse. If the alleged abuse took place in a residential or nursing home, other people could potentially be at risk and enquiries should be carried out with this in mind.

4.4 The CSCI 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.

There will be instances where allegations relate to one individual only and in these cases it may be appropriate to negotiate with the placing authority their undertaking certain aspects of the investigation. However, the host authority should retain the overall co-ordinating role throughout the investigation.

5. Responsibilities of placing authorities

5.1 The placing authority will be responsible for providing support to the vulnerable adult and planning their future care needs.

5.2 The placing authority should nominate a link person for liaison purposes during the investigation. They will be invited to attend any Adult Protection strategy meeting and/ or may be required to submit a written report.

6. Responsibilities of provider agencies

6.1 Provider agencies should have in place suitable adult protection procedures to prevent and respond to abuse which link with the local inter-agency policy and procedures set out by the host authority.

6.2 Providers should ensure that any allegation or complaint about abuse is brought promptly to the attention of Social Services, the Police, and/ or the CSCI in accordance with local inter-agency policy and procedures.

6.3 Provider agencies will have responsibilities under the Care Standards Act 2000 to notify their local CSCI area office of any allegations of abuse or any other significant incidents.

6.4 Provider agencies which have services registered in more than one local authority area will defer to the CSCI area office relevant to the area in which the abuse took place.

Appendix 8

Training Pathway

Safeguarding Adults Awareness Training

Target Group – all staff in all sectors

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Investigation Training

Target Group – Social Workers, Police Officers and those in the private and voluntary sector who may be involved in the investigation process

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Chairing Meetings under the 'Safeguarding Adults' Procedures

Target Group – All those with responsibility for chairing or managing those chairing meetings under the 'safeguarding adults' procedures

Within the Safeguarding Adults process the accurate and detailed recording of information is of the utmost importance. In order to support this process, it is therefore vital that relevant staff members receive minute taking training, specifically within Safeguarding Adult settings.

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Decision Making for Managers

Target Group – All those managing staff who may find, suspect or have abuse disclosed to them

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Support for those who are or have been victims of abuse and for those responsible for caring for those involved in abusive situations (if appropriate)

Travel along the training pathway must be dependant on the following:

- Ensuring those who attend the training fit the recommended target group
- All training should be multi – agency where possible
- Training should be updated every two years
- The training pathway should also be supported by individual workshops covering new developments and/or new legislation

Notes