Safeguarding Adults

Practice Guidance

2013

Review: December 2014

“Safeguarding is Everybody’s Business”
Section 1: Introduction

The safeguarding Adults Boards for both Derby City and Derbyshire County have agreed the overarching use of the term "Adult at Risk" in line with the recommendation of the Law Commission.¹ As such throughout the policy, procedures and practice guidance the terms "Vulnerable Adult" and "Adult at Risk" will be used interchangeably to accommodate phrasing and use of language.

Adults at Risk of Abuse

This operational guidance is for all agencies, staff and volunteers who have a responsibility for the care, support and protection of adults at risk.

Every person has the right to live a life free from abuse, exploitation and neglect.

Abuse occurs in all sections of society and there should be no discrimination because of assumptions about class, gender, age, disability, sexual orientation, race, religion, culture or eligibility for service.

Some people are more vulnerable to abuse than others because they are disempowered within society. People may be additionally vulnerable because of disability, age, impairment or illness.

Adults at risk of abuse must be made aware of their rights and given information, advice and support. They should be encouraged and enabled to access protection from the law and legal processes.

Every effort must be made to promote the well-being, dignity, security and safety of adults at risk of abuse consistent with their rights, mental capacity and personal choices.

In most cases, the adult at risk of abuse should be the person who decides on the chosen course of action, whilst being given all possible support. In a proportion of cases, an adult with mental capacity may choose to remain in an abusive environment or situation. In these cases it is still extremely important to consider what advice and support can be offered to reduce their risk from harm.

**Introduction**

**Your Practice and Preventing Abuse**

You can help to prevent abuse by:

- acknowledging that ‘it could happen here’
- being alert to signs of distress or intimidation
- reporting concerns at the earliest opportunity to your manager
- completing the Safeguarding Adults Referral Form
- being assertive in ensuring that the referral is passed on to the local authority, who will take the lead on safeguarding adults at risk
- taking opportunities for training and development
- asking for help if you feel you are ‘out of your depth’ with a particular issue
- being a Dignity in Care Champion
  - a Dignity in Care Champion is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. They believe that care services must be compassionate and person-centred, as well as
efficient, and are willing to try to do something to achieve this.

**Recognising abuse or neglect - Your responsibility**

It is vital to recognise abuse or neglect as early as possible and to take effective action. The practice guidance contains information about some possible causes, signs and symptoms that may help alert you to the fact that abuse or neglect is taking place. They may be relevant to any adult at risk, whether living in a domestic home, residential or nursing home or who is receiving services in other community settings, hospitals or in a custodial setting.

Every type of abuse is serious and you must deal with it in an appropriate way. This means reporting your suspicions to your manager or Agency Safeguarding Lead. Do not investigate it on your own. This is unacceptable and may result in the loss of vital evidence.

**Situations of Increased Risk**

Recent research indicates that the profile and circumstances of the alleged abuser are more significant than the profile or degree of dependence of the adult at risk of abuse. This is likely to be the same in both formal care and domestic settings. The following factors can make abuse more likely to occur;

If carers:

- Abuse alcohol or drugs
- Have stopped work specifically to provide care
- Have moved in with the adult at risk, specifically to provide care
- Have a history of abuse as a perpetrator or a victim
- Are under additional stresses such as illness, financial or marital problems
- Feel very lonely or isolated
- Habitually lose their temper, or have previously admitted to roughly handling the person for whom they are caring
- Are dependent on accommodation on the person for whom they are caring
- Are financially dependent in the person for whom they are caring or financially reliant on their estate
- Have expressed that they cannot cope or continue to provide care for the person
- Perceive the person they are caring for as being deliberately awkward
- Feel that the person they are caring for has failed to fulfil the carer’s own needs in former years.

(This list is not exhaustive)

The following factors in the adult at risk, may lead to an increased risk from abuse:

- Has a recently increased level of dependency because of behavioural difficulties such as restless wandering, confusion and incontinence, especially faecal
- Disturbs the carer at night
- Lacks purposeful activity
- Exhibits behaviours perceived to be odd or embarrassing
- Is not helpful or cooperative, is rejecting or ungrateful or will accept care only from a particular person.
- Has a difficulty in communication; for example through visual or hearing impairment, loss of or difficulty with speech, or a difficulty with memory and concentration.
- Change in behaviour or deteriorating illness

(This list is not exhaustive)
Dignity in Care

In 2007 the Department of Health initiated a campaign “to put dignity at the heart of care services”, whether care is given in a person’s own home or another care setting.

Social care and health agencies are responding actively to ensure that they meet the Dignity & Respect challenge, the principles of which underpin this adult safeguarding policy, procedures and practice guidance.

The “Dignity Challenge” states that high quality services that respect people’s dignity should:

- Have a zero tolerance to abuse
- Support people with the same respect you would want for yourself or a member of your family
- Treat each person as an individual by offering a personalised service
- Enable people to maintain the maximum possible level of independence, choice and control
- Listen and support people to express their needs and wants
- Respect people’s right to privacy
- Ensure people feel able to complain without fear of retribution
- Engage with family members and carers as care partners
- Assist people to maintain confidence and a positive self-esteem
- Act to alleviate people’s loneliness and isolation.
Section 2: Definition of Abuse

What is meant by Abuse?

Abuse is a violation of an individual’s human and civil rights by any other person or persons. It may be any real or potential infliction of physical or psychological harm, injury or pain that is the result of:

- a non-accidental act or conduct
- a non-accidental failure to act when there is a duty to act for example, neglect
- deprivation of services or treatment which are necessary to the adult’s health and safety by someone who has a duty to provide or ensure provision of such services or treatment
- Vulnerable Adults may become at risk of harm by:
  - abuse or exploitation by others
  - neglect or denial of services by others
  - denial of Human Rights
  - their lack of capacity to consent to specific risks

What is meant by Significant Harm?

Building on the concept of ‘significant harm’ introduced in the Children Act (1989), the Law Commission suggested that:

“Harm” should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development.\(^2\)

The seriousness or extent of abuse is often not clear when anxiety is first expressed. It is important, therefore, when considering the appropriateness of intervention, to approach reports of incidents or allegations with an open mind. In making an assessment of the seriousness of an allegation of abuse or neglect the following factors need to be considered:

- the **vulnerability** of the individual;
- the **nature and extent** of the abuse;
- the **length of time** it has been occurring;
- the **impact** on the individual; and
- the risk of **repeated or increasingly serious** acts involving this or other vulnerable adults\(^3\)

The safeguarding thresholds document can be used to assist practitioners in their decision making when considering the level of harm that may have occurred, or be likely to occur. \(^4\)

### What might cause Abuse or Harm?

Abuse or harm may be caused where:

- an unequal power relationship, whether physical, emotional, or financial exists between the abused and the abuser
- the Adult at Risk suffers from a chronic progressive illness that creates care needs which exceed the carer’s ability to meet them, such as dementia, parkinsonism, severe arthritis, severe cardiac disease and severe strokes
- the Adult at Risk lives with other family members who are financially dependent on them
- there is a personal or family history of violent behaviour, alcoholism, substance misuse or mental illness

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\(^3\) No Secrets (2000) Department of Health
\(^4\) Derby and Derbyshire’s Multi-Agency Thresholds Framework Guidance version 6 (2012)
- the carer feels emotionally or socially isolated
- minimal or no communication exists between the Adult at Risk and the carer either through choice, incapacity or poor relationship
- financial difficulties result in poor living conditions
- carers are not being helped by any practical or emotional support from other family members or professionals
- formal care settings that are influenced or motivated by profit, leading to poor care standards, minimal staffing, restrictive routines, lack of understanding about person centred practices, poor management, staff sickness or rapid turnover of staff

**Where might Abuse occur?**

Abuse can take place in any environment or context. It may occur when an Adult at Risk lives alone or with a relative; it may also occur within nursing, residential or day care settings, in hospitals, custodial situations, support services into people’s own homes, and other places previously assumed safe, or in public places.

Assessment of the environment and context is relevant because exploitation, deception, misuse of authority, intimidation or coercion may impact on a person’s ability to make their own decisions. Thus, it may be important for the adult at risk to be away from the sphere of influence of the abusive person or the setting in order to be able to make a free choice about how to proceed. **An initial rejection of support by the Adult at Risk should not always be taken at face value.**
Definitions of Types of Abuse

Within the policy and procedure the following terms are used to identify the main categories of abuse:

- Discriminatory Abuse
- Physical Abuse
- Sexual Abuse
- Psychological/Emotional Abuse
- Financial or Material Abuse
- Neglect or Acts of Omission
- Institutional Abuse

The following section sets out a definition of these categories in the order that they are found on the Safeguarding Adults Referral form. There are also some signs and symptoms listed which may assist in recognising and identifying abuse.

Other types of abuse have been grouped together under these broader categories to assist practitioners to complete Safeguarding records. However abuse may fall under a number of categories, and as such this list is neither prescriptive nor exhaustive. Any or all of these types of abuse may be perpetrated as the result of deliberate intent, negligence and/or ignorance.

The Safeguarding Adults policy and procedure specifically excludes self-harm and self-neglect. Adults at Risk in these circumstances may have needs that require assessment or action; however, they will not be dealt with under the Safeguarding Adults policy.
DISCRIMINATORY ABUSE

Discriminatory abuse includes psychological abuse, harassment and discrimination which is motivated by a person's age, gender, disability, sexual orientation, race, cultural background or religion. Discrimination may be a motivating factor in other forms of abuse such as domestic violence or hate crime.

Where the abuse or neglect is motivated by age, gender, sexual orientation, immigration status, racial, religion or disability; or occurs in a domestic violence situation; or perceived as a Hate Crime: the abuse will be considered to be aggravated by these factors.

Discriminatory abuse can be in the form of personal or institutional discrimination. Personal discrimination is the prejudice of the individual, whereas, Institutional discrimination is where systems and structures directly discriminate against potential or actual users of a service.

Signs and symptoms of Discriminatory Abuse can include:

- fearfulness expressed in the eyes, person avoids looking at the potential abuser, flinching on approach
- deference, resignation and passivity
- emotional withdrawal
- sleep disturbance
- low self-esteem
- unexplained fear or defensiveness
- isolation / shunning by others
- threats or intimidation, bullying or shouting
- unexplained attacks on property or possessions
- continual favouritism to other people in preference to the individual
• internalising the discrimination to the extent that they express similar discriminatory views about others

Other types of Abuse which could be considered Discriminatory:

• **Hate Crimes:** any incident which constitutes a criminal offence which is perceived by the victim or any other person as being motivated by prejudice and hate.

• **Ageism:** discrimination based on age, especially against the elderly.

• **Gender Discrimination:** is a belief that one sex is superior to the other and that the superior sex has endowments, rights, prerogatives and status greater than those of the inferior sex.

• **Homophobia:** discrimination against (fear or dislike of) homosexual people and homosexuality

• **Transgender Discrimination:** discrimination against people who are transgender

• **Religious Intolerance:** is either intolerance motivated by one's own religious beliefs or intolerance against another's religious beliefs or practices.

• **Racism:** is the hatred of one person by another or the belief that a person is less than human because of skin colour, language, customs or place of birth

• **Disablism:** discriminatory, oppressive or abusive behaviour arising from the belief that disabled people are inferior to others.

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**PHYSICAL ABUSE**

Physical Abuse is the physical mistreatment of one person by another which may or may not result in physical injury. Physical abuse includes assault, hitting, slapping, scratching, pushing, kicking, pinching, burning, force-feeding, misuse of medication or the withholding of medication or treatment, unwarranted or inappropriate restraint, forced isolation or inappropriate sanctions, unwarranted or unauthorised
deprivation of liberty, false imprisonment or abduction, rough handling causing injury or any injury not fully explained by the history given.

**Signs and symptoms of Physical Abuse can include:**

- unexplained bruises or welts on body, including face, lips, mouth, body, arms, back, buttocks, thighs
- bruises in various stages of healing, clusters forming regular patterns, reflecting the shape of an article or finger marks
- unexplained burns, especially on soles, palms and back, immersion burns, rope burns, electric appliance or carpet burns
- unexplained fractures to any part of the body, especially if in various stages of healing, multiple or spinal injuries
- unexplained lacerations or abrasions to the mouth, lips, gums, eyes, external genitalia
- Recoiling from physical contact or flinching
- malnutrition – rapid or continuous weight loss, insufficient supply of food on premises, dehydration, complaints of hunger
- lack of personal care, inadequate or inappropriate clothing, inadequate heating
- untreated medical problems
- unmanaged urinary / faecal incontinence
- signs of medication misuse such as drowsiness
- Use of furniture and other equipment to restrict movement.

**Other types of Abuse which could be considered Physical:**

- **Domestic Violence:** any incident, or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners, or family members regardless of gender or sexuality.\(^5\)

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\(^5\) Domestic Violence Multi-Agency Staff toolkit
- **Forced Marriage**: is a marriage conducted without the valid consent of one or both parties where duress is a factor. Forced Marriage is a violation of internationally recognised human rights and contrary to the Matrimonial Causes Act 1973. See Appendix One for more information.

- **'Honour' Based Violence**: is an incident or crime carried out to protect or defend the honour or 'izzat' of the family or community. This type of violence can be distinguished from other forms of violence as it is often committed with some degree and / or collusion from the family and / or community. Honour based violence includes acts of harassment, assault, imprisonment, unexplained death (suicide), forced pregnancy / abortion and in some cases murder. The family may perceive that the person has acted inappropriately and dishonoured the family and community. Consequently, the violence carried out is to punish them for this. For more information about honour based violence visit Karma Nirvana’s website [www.karmanirvana.org.uk](http://www.karmanirvana.org.uk).

- **Unauthorised Deprivation of Liberty**: depriving someone of their liberty is illegal in care homes and hospitals unless authorisation has been granted by the Local Authority. Deprivation of liberty may be in some people’s best interests. Where a number of restrictions are applied to a person who may lack capacity to consent to the care being applied, including when they are compliant, a deprivation of liberty may exist. A Best Interest Assessor from the Local Authority will be requested to decide if a deprivation of liberty is occurring and if it is in the best interests of the Adult at Risk. Where a deprivation of liberty is occurring that is not subject to the Deprivation of Liberty Safeguards legislation, for example in a private dwelling, then the Adult Safeguarding procedures must be invoked. Where it is

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considered appropriate the Court of Protection must be asked to review the circumstances and authorise the deprivation of liberty. Where people are deprived of their liberty without the legal authority to do so then action under the criminal law can be considered by the Crown Prosecution Service.

- **Environmental Abuse**: includes depriving someone of their liberty, sustained restrictions on a person’s freedom of movement as a result of the physical environment the person is in, culture of the environment or institution.

**SEXUAL ABUSE**

Sexual abuse is the involvement of individuals in sexual activities to which they have not had the freedom and capacity to give their informed consent to, before and during the act, and/or may not fully comprehend. These acts include rape and attempted rape, sexual assault by penetration, sexual assault, abuser touching the victim’s body for their own gratification, indecent exposure, non-contact abuse (pornography), sexual harassment, causing or inciting a person to engage in sexual activity without their consent.

**Signs and symptoms of sexual abuse can include:**

- full or partial disclosure or hints of sexual abuse
- signs of depression, stress
- recoiling from physical contact
- unusual difficulty in walking and sitting
- torn, stained or bloody underclothing
- pain or itching, bruises or bleeding in genital area
- sexually-transmitted disease, urinary tract / vaginal infections
- love bites, bruises or finger marks on thighs or arms
- significant change in sexual behaviour, language or outlook
- Fear of males or females
• pregnancy in a person who is not able to consent
• onset of faecal or urinary incontinence for no apparent reason

Other types of Abuse which could be considered Sexual:

• Female Genital Mutilation: (FGM) is a collective term for procedures which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. See Appendix Two for more information.

• Sexual Exploitation: Sexual exploitation of vulnerable adults involves exploitative situations, contexts and relationships where the vulnerable person receives ‘something’ (e.g. food, accommodation, drugs, alcohol, SIM cards and mobile phones, cigarettes, affection, gifts, money) or perceived friendship/boyfriend as a result of them performing, and/or others performing on them, sexual activities. See Appendix Three for more information.

PSYCHOLOGICAL / EMOTIONAL ABUSE

Psychological or emotional abuse is action or neglect by a person which impairs the psychological wellbeing of another person. This results from being repeatedly made to feel unhappy anxious afraid humiliated or devalued by the actions or inactions and/or attitudes of others and includes emotional abuse, threats of harm or abandonment, deprivation of contact, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

Signs and symptoms of Psychological/Emotional abuse can include:

• fearfulness expressed in the eyes, avoids looking at the caregiver, flinching on approach
• ambivalence to carer
• deference, resignation and passivity
• emotional withdrawal
• sleep disturbance
• low self-esteem
• unexplained fear or defensiveness
• threats or intimidation, bullying or shouting
• significant pressure on a person to commit criminal acts
• threat to abandon person or put them “away”
• promises which are not kept
• punitive approach to bodily functions or incontinence
• few visitors, phone calls or outings
• locking the person in at home, or in a car
• significant community pressure for example anti-social behaviour

Other types of Abuse which could be considered Psychological:

• Anti-Social Behaviour: acting in a manner that caused or was likely to cause harassment alarm or distress to one or more persons not of the same household as the defendant.
• Discriminatory Abuse: as described above
• Cyber Abuse: the use of technology and social networking sites to threaten, bully, harass, groom for exploitation, stalk, pose risks to personal safety and wellbeing or discriminate against an adult at risk. This could be through the use of a PC, Laptop, tablet, mobile phone, gaming console or Television with internet access. Threats can come through content, contact and conduct. This includes text messages, phone calls, pictures, video clips, emails, chat room messages, instant messaging and websites. Signs and symptoms can include spending long periods of time online, secrecy about a mobile phone and/or computer, withdrawal from

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8 See information on The Prevent Strategy [http://www.homeoffice.gov.uk/counter-terrorism/review-of-prevent-strategy/]
social contact, depression, mood swings, unexplained gifts, sleep disturbance and self-harming. For more information see http://www.digital-stalking.com/

**FINANCIAL OR MATERIAL ABUSE**

Financial abuse is the misappropriation of an individual’s funds, benefits, savings, assets etc. or any other action that is against the person’s best financial interests. This includes theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, denying access to money, or the misuse or misappropriation of property, possessions or benefits.

**Signs and symptoms of Financial/Material Abuse can include:**

- unusual or inappropriate bank activity
- a Power of Attorney obtained when a person is unable to comprehend
- recent change of deeds or title of house
- person lacks belongings or services which they can clearly afford
- recent acquaintances expressing sudden or disproportionate affection for a person with money or property
- carer asks only financial questions of the worker, does not ask questions about care
- withholding money
- person managing financial affairs is evasive or uncooperative

**Other types of Abuse which could be considered Financial or Material:**

- **Distraction Burglary:** The Home Office Definition of distraction burglary is any crime where a falsehood, trick or distraction is used on an occupant to gain, or try to gain, access to the premises to commit burglary. It includes cases where the offender
first enters the premises and subsequently uses a distraction burglary method in order to remain on the premises and / or gain access to other parts of the premises in order to commit burglary.

**NEGLECT AND ACTS OF OMISSION**

Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support

Section 44 Mental Capacity Act 2005 states “Anyone who has a duty of care to a person who lacks capacity is guilty of an offence if they deliberately or recklessly ill-treat that person or if they wilfully neglect that person.”

It does not matter whether the behaviour was likely to cause, or actually caused, harm or danger to the victim's health. Wilful neglect usually means that a person has deliberately failed to carry out an act they knew they had a duty to do.

Where there is concern that neglect may be a contributory cause of death of an Adult at Risk, the deceased adult will be subject to these procedures, where necessary, to investigate and assess any risks to any other vulnerable adult. It may also be appropriate for the coroner to be notified of the concerns, so they can instruct the police, if required, to gather evidence on their behalf. See section 'Working with the coroner'.

**Signs and Symptoms of Neglect and Acts of Omission can include:**

- physical condition of the person is poor
- unexplained or untreated deterioration in health and wellbeing, including not seeking appropriate medical attention

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9Section 44 Mental Capacity Act 2005. Available from:  
http://www.opsi.gov.uk/ACTS/acts2005/ukpga_20050009_en_4#pt1-pb10-l1g44
• inadequate heating or lighting
• poor personal hygiene
• malnutrition – loss of weight
• dehydration
• demanding food or drink
• pressure sores
• inconsistent or reluctant contact with health or social agencies
• lack of social support and/or refusal to arrange access to callers / visitors
• inappropriate, old or shabby clothing, or being kept in night clothes during the day
• sensory deprivation, not allowed to have hearing aid, glasses or other aids to daily living
• accumulation of medication, or prescriptions not being collected from pharmacy
• increased number of incidents or accidents e.g. falls or physical altercations with others, which appear to have resulted from a lack of supervision both inside and outside of the home environment.

INSTITUTIONAL ABUSE

Institutional Abuse is abuse that arises from an unsatisfactory regime. It occurs when the routines, systems and norms of an institution override the needs of those it is there to support. Such regimes compel individuals to sacrifice their own preferred life style and cultural diversity in favour of the interests of those there to support them, and others. This can be the product of both ineffectual and punitive management styles, creating a climate within which abuse of Adults at Risk, intentional or otherwise, is perpetrated by individual staff and others. There is a lack of good leadership within the institution and members of staff are not equipped to carry out the care required. See Appendix Four for more information.
Signs and Symptoms of Institutional Abuse can include:

- Inappropriate or poor care
- Misuse of medication
- Inappropriate restraint Sensory deprivation, e.g. denial of use of spectacles or hearing aid
- Lack of respect shown to the Adult at Risk
- Denial of visitors or phone calls
- Restricted access to bathing or toilet facilities
- Restricted access to appropriate medical or social care
- Failure to ensure appropriate privacy or personal dignity
- Lack of flexibility and choice, e.g. mealtimes and bedtimes, choice of food
- Lack of personal clothing or possessions
- Lack of adequate procedures, e.g. for medication, financial management
- Controlling relationships between staff and service users
- Poor professional practice
- Lack of staff training

RISK OF ABUSE/NEGLECT

An alert and referral will be made where:

- Systems of care provided to adults at risk are **highly likely and imminently** to result in the abuse/neglect of a known adult at risk
- An individual is assessed as being at imminent risk of harming **known** adults at risk

Indicators of individuals who may pose an imminent risk of harming adults at risk **may** include:
o Individuals convicted of offences that indicate they may be a risk to children or adults

o Individuals known to have been cautioned/warned or reprimanded in relation to an offence against children or adults

o Individuals against whom there is a previous finding of fact in civil proceedings

o Those about whom there has been a previous safeguarding children or adult enquiry which came to the conclusion that there had been abuse

o An individual who has admitted past abuse of a child or adult

o Offenders convicted of serious crimes against adults who are notified to the local authority, because the prison or probation services or police are concerned about the possible risk to adults at risk

o Offenders who come to the attention of the MAPPA

o A person barred by the Disclosure and Barring Service

o Where there is a concern that an individual poses a risk to adults, but there is no information available as to any known and identifiable adults who may be at risk, then partner agencies will ensure investigations are made and information is shared with due regard to the requirements of:
  • The Crime and Disorder Act (1998)
  • Disclosure and Barring Service
  • Derbyshire Multi Agency Public Protection Arrangements (for more information contact the MAPPA Coordination Unit/Public Protection Unit based at Derbyshire Constabulary Headquarters (01773 572271)
  • Derby or Derbyshire Multi-Agency Risk Assessment Conference (MARAC).
  • Appropriate professional bodies e.g. Nursing and Midwifery Council, Health Care Professionals Council etc.
The Safeguarding Managers are available to facilitate the sharing of information in these cases. This may include meeting with relevant agencies and employers.

**Patterns of Abuse**

Every type of abuse and neglect is serious. Patterns of abuse and abusing vary and reflect very different dynamics. These include:

- **Serial abusing** in which the perpetrator seeks outs and “grooms” vulnerable individuals. Sexual abuse usually falls into this pattern as do some forms of financial abuse
- **Long term abuse** in the context of an ongoing family relationship such as domestic violence between spouses or generations
- **Opportunistic abuse** such as theft occurring because money has been left around
- **Situational abuse** which arises because pressures have built up and / or because of behaviour that challenges
- **Neglect of a person’s needs** because those around him or her are not able to be responsible for their care, for example if the carer has difficulties attributable to such issues as debt, alcohol or mental health problems
- **Institutional abuse** which features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service
- **Unacceptable ‘treatments’ or programmes** which include sanctions or punishment such as withholding of food and drink, seclusion, unnecessary and unauthorised use of control and restraint or over-medication
- **Failure to access key services** such as health care, dentistry, prostheses
- **Misappropriation of benefits** or use of the person’s money by other members of the household
• **Fraud or intimidation** in connection with wills property or other assets
Section 5: Safeguarding Investigations

**Why and How are Investigations carried out**

The purpose of any investigation is to:

- Protect the adult at risk from serious harm and offer them support
- Establish and record the facts about the circumstances giving rise to the alert
- Establish evidence for formal proceedings (e.g. criminal, registration or disciplinary)
- Establish with the adult at risk whether they feel that their personal safety is at risk, whether they want professional intervention to occur and what their views are on sharing information about the incident with other staff that need to know
- Decide if protective or other action is needed for the adult at risk or others
- Identify the sources and levels of risk
- Decide whether actual or suspected abuse has taken place and record the reasons for these conclusions
- Ensure that appropriate action is taken in respect of any perpetrator
- Identify any lessons to be learnt for the future, including recommending changes to existing practices or service delivery

The tasks that need to be undertaken will include the following:

- Carry out a comprehensive assessment
- Assess the mental capacity of the adult
- Determine the need for medical intervention relating to the physical, or mental, state of the adult at risk
- Liaison with the police
- Decide whether legal advice needs to be sought
• Ascertain the need for a Case Conference
• Consider the different methods of gathering and presenting evidence
• Consider the communication needs of the adult at risk and ensure that an appropriate service is offered (this includes people with dementia, those whose first language is not English, people with sensory impairment, people who have learning difficulties or people with acute mental health issues)

It is important that information is shared throughout the investigation process. This will include keeping the alertor, or referring agency, appropriately informed of progress and likely timescales for decisions and outcomes, within the principles of information sharing (see Information Sharing section of this practice guidance for more information.)

**Planning the Investigation**

Consideration of the following points is important to inform the decision-making process and the way in which the investigation should be planned?

• Who should be interviewed?
• What support is needed for when interviews take place?
• The available sources of evidence which could include written records, statements from witnesses, forensic and medical evidence
• Where will be interviews take place
• The sequence of interviews
• Who will conduct the interviews?
• The need for medical examinations
• The degree of risk to the adult at risk, including:
  ➢ The risk of repeated or escalating acts
The extent of the abuse
The length of time that the abuse has been occurring
The impact upon the individual
The urgency of the situation and whether immediate action is needed
The rights and wishes of the people involved
The legal framework under which the investigation will pursued

Consideration should be given to whether alerting the person alleged to have carried out the abuse might further jeopardise the safety of the adult at risk, or the collection of evidence. At this stage it may be useful to seek legal advice about the involvement of the perpetrator.

Decisions about who should be informed about the alleged abuse need to be made; in particular any agencies involved with the adult at risk. It will be appropriate, usually, to inform a family member should the adult at risk consent.

The reasons for decisions being taken, or not taken, must be recorded.

If the person allegedly responsible for the abuse is also an adult at risk then the investigation should ensure an assessment of their needs is also undertaken. In this instance a separate Case Conference may need to be convened.

**Who Might be Involved**

The investigation may have several strands, all of which require careful co-ordination. This co-ordination should take place at the strategy / discussion meeting stage.
Police - the police investigation considers whether a crime has been committed. The police will not lead a multi-agency Safeguarding Adults Investigation, however where criminal offences are suspected, criminal investigations must have primacy over other enquiries. The police will work closely with adult social care services and other relevant agencies to ensure that the welfare and care of adults in need of safeguarding is considered while ensuring that nothing is done in any other part of the investigative process that could interfere with the criminal investigation.

In order to prosecute there must be sufficient evidence that an offence has been committed ‘beyond all reasonable doubt.’ Insufficient evidence to support a prosecution does not mean that there may not be steps that need to be taken in response to the alleged abuse to protect the alleged victims/s. There steps may include:

- Action by Care Quality Commission (CQC)
- Disciplinary action by employers
- Legal Actions
- Action by contracts department

Contracts Department: A contracts department will investigate any breaches in the contractual arrangements made with a provider. They may also need to liaise with contracts departments with other local authorities or health trusts as appropriate.

Care Quality Commission (CQC): The CQC will investigate allegations concerning the standards of care provided by a registered health or social care service provider. CQC and works with the provider to ensure safe working practices and improved standards to ensure continuing protection for the alleged victim and adults who may be affected. Where improvements are not made the CQC has powers to take certain actions, including enforcement against the registered manager/provider.
**Disciplinary Investigation:** The disciplinary investigation will be led by the employing agency following their own internal disciplinary procedures. It will ascertain whether the staff member has been guilty of misconduct or gross misconduct in the course of his or her duties. As well as the allegation of abuse the disciplinary investigation will also consider whether a referral to the Disclosure and Barring Service is required.

**Adult Social Care Services/ Health Service Led Investigation:** They will make an assessment of actions necessary to ensure continuing protection for the alleged victim and any other adults who may be affected. Decisions will be based on professional judgement of the information presented.

**Investigator’s Interviews**

The adult at risk should not be interviewed alone or in the presence of the person alleged to be responsible for the abuse, after the first disclosure or alert, if there is any possibility that an offence may have been committed. In such cases a joint interview is preferable at which the adult at risk may be accompanied by any, or several of the following:

- An independent advocate
- A family carer,
- Member of their family,
- Close friend,
- Supporter or
- Person of the Adult at Risk’s choice

Care should be taken to ensure that a premature determination of abuse does not occur. No plan of action, except in emergency
circumstances, should be initiated until the facts surrounding the alleged abuse have been established.

**Carrying out an Interview**

During the interview the Investigating Officer should ensure that:

- Information about their designation and the agency represented is stated clearly
- The purpose of the interview is made clear
- The nature of the allegation is identified
- How the interview is carried out is explained
- How the interview will be recorded and for what purposes
- A relaxed and caring manner is adopted
- An attempt is made to establish how the alleged abuse occurred
- Suitable breaks are agreed and adhered to

**Investigation Evidence**

The investigation will consider:

- Was / is the situation abusive
- Is this an isolated concern, or have similar concerns / complaints been expressed previously
- What evidence / indicators are there
- What facts can be established about what happened, when and by whom
- How long has the situation been going on
- How does the alleged victim perceive the alleged abuse
- What is the victim’s mental capacity to make specific decisions
- How does the alleged perpetrator perceive the alleged abuse
- What action does the alleged victim wish to see taken regarding the alleged abuse
- Could the alleged victims decision and action have been unreasonably influenced by someone else
- What is the impact to the victim
- What are the rights and wishes of those involved
- What is the legal context
- Have there been any breaches of contract or regulation
- What could have been done to prevent the abuse occurring
- Staffing issues
- Review of policy / procedure / practice

**Investigator’s Report**

The report will need to cover the following areas:

- Details of the initial alert
- Outline of the current and any previous allegations
- An assessment of the seriousness of the abuse
- Possible causal factors
- Background information about the adult at risk
- Issues and opinions relating to consent and capacity
- Information about the alleged perpetrator
- A description of the Investigation process (what was involved) and the level of co-operation received from those consulted
- Presentation and evaluation of evidence
- A view about current and future risks and plans to manage those risks
- Recommendations about future action and rationale for this (protection/ safety planning)
Large-Scale/ Institution-Wide Investigations

In addition to this guidance regarding all investigations, there may be additional considerations required in large scale / institution-wide investigations.

Whenever abuse is alleged or suspected, it is important to consider whether any other adults in need of safeguarding, could be at risk.

The need for a large-scale investigation is evident where it is suspected that a number of adults in need of safeguarding have been abused:

- In the same setting
- By the same perpetrator
- By a group of perpetrators

In all multi-agency investigations, there will be a variety of agencies involved and the investigative process may comprise of several individual investigations. Within a large-scale investigation, this will certainly be the case and it is imperative that a strategy meeting / discussion should be held among all agencies at the earliest possible time.

It is recommended that this be an actual meeting rather than simply phone or email contact, given the number of organisations who may be involved and the need for clarity on the role of each agency / professional.

The strategy meeting may need to consider the following issues in addition to standard procedure:
• Immediate safety of all individuals involved. This may include the need to suspend or relocate a number of staff. Arrangements may need to be made for alternative accommodation or care provision for a number of individuals

• Agree who may need to be involved such as CQC, contracts departments and / or other local authorities and Health Trusts

• Agree how best to co-ordinate the investigation and who has overall responsibility for co-ordination and chairing of any subsequent meetings

• Agree roles and responsibilities of each agency and individuals involved and ensure that all are aware of how their part in the investigation fits in to the overall multi-agency process

• Decide who needs to be notified of the investigation, who is best placed to do this and how it should be done. Those who need to be notified include senior management, organisational Safeguarding Adults leads, legal services, elected members, family and relatives of those adults who may be at risk

• Consider resource implications around the number of investigators needed, the facilities for conducting the interviews, funding to re-locate individuals at risk etc.

• Consider how to support that alleged victim/s and their family / carers through the process and following conclusion, including the possibility of advocacy services, support groups etc.

• It may be useful to have in mind a checklist of questions appropriate to the particular case details (see question phase for advice on types of questions to use)

Further information can be found in the Commissioning and Safeguarding section of this practice guidance.
Closing the Investigation

Prior to closing an investigation the Investigating Officer should ensure that:

- All verbal and written records have been completed
- The case file contains all the necessary information and forms
- Agencies who are involved in the Adult Protection/Safety Plan are aware of their responsibility to re-refer the adult at risk should circumstances change or risks increase
- Adult Protection/Safety Plan has been implemented
- All decisions have been recorded in writing with evidence to support the decisions clearly documented
- The reasons for closing the investigation are fully recorded

Once the investigation has been completed, there should be clarity about whether on the balance of probabilities, abuse has taken place. Any decisions regarding case closure should be agreed and fully recorded. Cases can be closed at any stage of the investigation with the agreement of the agencies involved. The decision should detail any investigation with the agreement of the agencies involved. The decision should detail any interventions put in place in respect of both the victim and the perpetrator.

Prior to closing an investigation there should be regard to the following:

- The reason for closure must be agreed and the decision must be recorded explaining the judgement, reason and defensible decision for the actions taken
- The case file must contain all the necessary information, minutes, forms and reports
- A decision should be made on how the information is to be shared with the adult at risk of abuse
• All decisions should be recorded and be defensible
• The adult at risk and their family views carers’ (if appropriate) of the outcome and process are recorded
• The adult at risk is fully informed and aware of the details of the safeguarding plan and review process
• Consideration must be given as to whether any staff, alerter, whistleblower, carers need additional support.

**Definitions of Safeguarding Conclusions**

Safeguarding conclusions are drawn on the balance of probabilities. This means that when reaching a decision, the evidence suggests that that the abuse was more likely to have occurred than not.

**Substantiated – fully:** This refers to cases where “on the balance of probabilities” it was concluded that all the allegations made against the individual or organisation believed to be the source of the harm or neglect were proved. Where allegations of multiple types of abuse are being considered against an individual or organisation then all will need to be proved for it to be defined as fully substantiated.

**Substantiated – partially:** This refers to cases where there are allegations of multiple types of abuse being considered against an individual or organisation. Verification will be partial where “on the balance of probabilities” it was concluded that one or more, but not all, of the alleged types of abuse were proved. For example, a referral that includes allegations of physical abuse and neglect, where the physical abuse can be proved on the balance of probabilities, but there is not enough evidence to support the allegation of neglect will be partially substantiated.

**Inconclusive:** This refers to cases where there is insufficient evidence to allow a conclusion to be reached. This will include cases where, for
example, the individual subject to the referral, the individual believed to be the source of the risk or a key witness passed away before they could provide statements as part of the assessment or investigation.

**Not-substantiated**: This refers to cases where “on the balance of probabilities” the allegations are unfounded, unsupported or disproved.

**Investigation ceased at individual’s request**: This refers to cases where the individual at risk does not wish for an investigation to proceed for whatever reason and so preclude a conclusion being reached. Referrals which proceed despite this, for example where a local authority has duty of care to protect other residents in a care home setting or multiple individuals in supported housing, will not come under this definition.
Section 6: Minimum Standards for Recording Information for Safeguarding Cases

Recording Standards

When recording contacts, referrals and logs in relation to Safeguarding Adults Cases there are minimum standards for the information recorded. This is to ensure consistency in approach and decision making. All necessary information should be gathered, recorded and considered when making decisions about how to proceed with a safeguarding case. This information is needed to make a clear, logical, structured and accountable decision.

Good quality records provide an audit trail, enable others to understand the decision making process that has been followed and find information without having to hunt around for it. All records should be:

- accurate
- factual
- ethical
- relevant
- dated
- timely
- complete - No abbreviations should be used

In the case of handwritten records, these should be legible, in back ink and signed.

It is important to remember that records are evidence and may be called in legal proceedings, professional misconduct hearings or for Serious Case Reviews. Also, the Data Protection Act 1998 gives
individuals the right to access their health and social care records held manually or on computer.

When receiving the initial Safeguarding Referral, it may be necessary to contact the adult at risk to collate further information, unless there are issues of capacity, in which case contact may be made with an appropriate relative or friend. Contact should not be made with the alleged perpetrator.

**Safeguarding Referrals**

All safeguarding referral related recording should include the following as a minimum:

- Your name, designation and team
- Date and time of receipt of information
- Who the information is from, their contact details and what their relationship to the alleged victim is (i.e. husband, wife, son, daughter, doctor, nurse etc.)
- What format the information is in? (i.e. letter, fax, telephone call, discussion during home visit, etc.)
- What is the information? What are the facts? Opinions should be clearly marked as such.
  - What has happened?
  - How has it impacted/affected the adult at risk? (i.e. injury, distress, harm etc.)
  - Where has it happened?
  - When did it happen?
  - Who was involved?
  - How does the alleged victim meet the definition of a “adult at risk”
- Record information about any community care needs including any information on communication needs.
• What action was taken at the time of the incident/disclosure?
(I.e. police or ambulance called, staff member suspended, family notified, GP attended etc.)

• Is the adult at risk aware and agreeing to the referral?
  o Has the adult at risk got capacity to make this decision?
  o Are there any reasons to override lack of consent? (I.e. risks to others, child safety concerns, public safety etc.)

• What does the adult at risk want to happen?
  o Has the adult at risk got capacity to make this decision?
  o Is there possibly any intimidation, undue influence, stresses or pressures which is affecting the response being given by the adult at risk
  o Are there any reasons to override lack of consent? (I.e. risks to others, child safety concerns, public safety concerns etc.)

• What risks have been identified?
  o To the alleged victim/adult at risk?
  o To other adults at risk/children?
  o To any carers, family or friends involved?
  o To any professionals or others?
  o Are the risks past, present or future (or a combination)?

• What action has been taken in relation to the risks?

• Following the information received in the referral, what is the decision about how to proceed and why?
  Does the information meet the safeguarding threshold; what is the rationale for your decision
  o Is further information needed in the form of a strategy discussion/meeting and Safeguarding Adult investigation?
  o Who has been consulted/taken advice from on this decision? (i.e. line manager)
  o What factors have been taken into account?
  o Have you signposted or provided information/advice to anyone?
What actions need to be taken, by whom and by what time?
- What feedback have you given to the referrer?

Safeguarding Referral Forms should be indexed to the electronic social care record as a priority on the day they have been received, and a Contact recorded on the system.

**Safeguarding Strategy Discussion/ Meetings**

Records of Strategy discussions and Strategy meetings should be completed on specific record forms. This form should be completed in liaison with the co-ordinating officer/ safeguarding lead. The Strategy discussion document forms part of your risk assessment and protection plan, it is important to complete all sections of the form. This form should be indexed to the electronic social care record as soon as is practicable after the discussion/meeting. A log should also be put on Case Notes on the date of the discussion/meeting, detailing who was in attendance/ consulted and the actions agreed.

**Safeguarding Investigations**

All visits, actions, correspondence etc. in relation to the Safeguarding Investigation should be recorded in Case Notes, in line with organisational recording policies. An overview of the Safeguarding Investigation, including details of specific visits/ evidence should be written up on the specific Investigation form. A log should be recorded in the Case Notes to identify the completion of this document.

**Case Conferences**

Records of case conferences should be completed on the specific record forms. This form should be completed in liaison with the co-ordinating officer/ safeguarding lead. The case conference document forms part of your risk assessment and protection plan, it is important
to complete all sections of the form. This form should be indexed to the electronic social care record as soon as is practicable after the discussion/meeting. A log should also be put on Case Notes on the date of the case conference, detailing who was in attendance/consulted and the actions agreed.

**Safeguarding Logs/ Case Notes**

All other Safeguarding Adults Logs/ Case Notes should ensure that the recording standards detailed above are followed. The adult at risk should be consulted and their views should be clearly recorded. Risks should be discussed directly with the adult at risk and this discussion should be clearly documented. Decision making should be clear and based on the facts available; a rationale explaining why a specific decision has been made and any alternatives considered should be recorded.

**Defensible Decision Making**

Defensible decision making is about recording a clear rationale for all the decisions made. This includes the discussions that led to the decisions and the legislative context. The following principles should be adhered to when working with adults at risk:

- Agency process and procedures should be followed.
- Recording should demonstrate proper process has been followed and reliable assessment methods followed.
- Actions taken and decisions made are through consultation and are reasonable and proportionate.
  - J – JUSTIFIABLE
  - A – AUTHORISED
  - P – PROPORTIONATE
  - A – ACCOUNTABLE
  - N – NECESSARY
• Decisions should be recorded and evidenced as being completed with clearly identified reviewing timescales.

• A decision not to follow safeguarding procedures should be explicitly recorded with a detailed rationale.

• Recording processes need to be consistent throughout the decision making process. Practitioners are required to demonstrate when and how intervention will/has been made and by whom.

• Recording processes should provide a clear audit trail. There will be regular case audits completed which will support practice development and also recognise good practice.
Section 7: Disclosure of Historical Abuse By an Adult

Introduction

When an adult discloses that they were abused as a child or that they have been abused as an adult, but it is historical, the response should be the same from agencies as if they were responding to an allegation of current abuse.

It should be made clear from the outset that information disclosed may need to be shared, without consent if necessary.

What to do when an adult discloses they were abused as a child under the age of 18

Where an Adult discloses to Adult Services that they were abused as a child under the age of 18 then a referral should be made to Children’s Social Care in the area that the abuse took place, in a timescale that protects children.

If an adult discloses information that leads a practitioner to become concerned about a child’s safety the practitioner should endeavour to establish the identity of the alleged perpetrator’s recent or current whereabouts.

Children’s Social Care can only act to safeguard a child if they know who the child is and where s/he lives. The practitioner should be careful to accurately record what is said to them and to discuss the matter with their manager; they may also wish to take advice from their designated lead for child protection.
If it is known that a specific child is in contact with the alleged abuser an urgent referral should be made to Children's Social Care wherever they live. Children's Social Care will discuss the matter with the Police and Safeguarding Children Manager/Child Protection Manager. In circumstances where the name of a child is not known but where there is a specifically identifiable risk or where there are believed to be several children involved the practitioner (or their manager) should speak to the Safeguarding Children Manager/Child Protection Manager who will consider the need for a strategy meeting with the referring agency, Children's Social Care and the Police. That meeting may need to give consideration to the possibility of complex or organised abuse procedures. This should be done in a time-frame that is not detrimental to the child's interests.

Children's Social Care should liaise with the Police and the referring agency to ensure that the adult survivor is kept appropriately informed of progress.

It is important to keep the adult survivor informed of progress (where possible and appropriate) as they may have real anxieties about the consequences of their disclosure and may have concerns for their personal safety and practitioners should establish a clear understanding of who will ensure that this work is done.

Consideration should be given to any Safeguarding Adults implications and procedures should be followed as appropriate, where the alleged perpetrator may have access to adults at risk.

Practitioners can obtain advice and support on this issue from the Safeguarding Adults Managers.

**Support lines/websites Available for Support**
(list not exhaustive)
• Support Line 01708 765200 – provides emotional support to male and female survivors of abuse and associated issues.
• Ann Craft Trust 0115 951 5400 – national information and advice service on all aspects of sexual abuse and exploitation of adults
• Childwatch -1482 325 552 – free and confidential counselling for young people and adults who have experienced abuse.
• NAPAC (National Association for People Abused in Childhood) - 0800 085 3330 www.napac.org.uk
• Rape and Sexual Abuse Support Centre – 0808 802 9999 (helpline)
• AMOSA UK (Adult Male Survivors of Sexual Assault – 0845 430 9371 www.amosa.com
• The Mankind Initiative - 01823 334244 national telephone helpline providing counselling, support and information to men who have experienced abuse www.mankind.org.uk

**What to do when an adult discloses they were abused as an adult over the age of 18**

When an adult discloses that they were abused as an adult, but is historical, the response should be the same from agencies as if they were responding to an allegation of current abuse. As such Derby and Derbyshire’s Safeguarding Adults multi-agency policy and procedures should be followed.
Section 8: Risk Assessment and Management Guidance

The aim of this guidance is to enable workers to assess risk in a person-centred, holistic and systematic manner, and to facilitate accurate and comprehensive recording of all risk assessments completed. This guidance has been produced from the principles of the Department of Health policy, "Independence, Choice and Risk: a Guide to Best Practice in Supported Decision Making" (2007). Please see the document for more information at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074773

What is Risk?

- There is no one definition of risk.
- Risk describes the amount of uncertainty or variability around an expected outcome
- People perceive risk differently
- Risk is often viewed negatively and can prevent people from doing things that most people take for granted

What is reasonable risk?

- It is about striking a balance between empowering people to make choices, while supporting them to take informed everyday risks
- The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same.

Workers need to:

- Help people to have choice and control over their lives
• Recognise that making a choice can sometimes involve an element of risk
• Help people understand their responsibilities and the implications of their choices including any risks
• Acknowledge that there will often be some risk, and that trying to remove it altogether can outweigh the quality of life benefits for the person

**Situations of Increased Risk**

Recent research indicates that the profile and circumstances of the alleged abuser are more significant than the profile or degree of dependence of the adult at risk of abuse. This is likely to be the same in both formal care and domestic settings. The following factors can make abuse more likely to occur

If carers:

• Abuse alcohol or drugs
• Have stopped work (or have moved in with the adult at risk) specifically to provide care
• Have a history of mental illness or distress
• Have a history of abuse as a perpetrator or a victim
• Are under additional stresses such as illness, financial or marital problems
• Feel very lonely or isolated
• Habitually lose their temper, or have previously admitted to roughly handling the vulnerable adult
• Are dependent on accommodation with the person for whom they are caring
• Have expressed that they cannot cope or continue to provide care for the adult at risk
• Perceive the adult at risk as being deliberately awkward
Feel that the person they are caring for has failed to fulfil the carer’s own needs in former years
(This list is not exhaustive)

The following factors in the adult at risk may lead to an increased risk from abuse:

- Has a recently increased level of dependency because of behavioural difficulties such as restless wandering, confusion and incontinence, especially faecal
- Disturbs the carer at night
- Lacks purposeful activity
- Exhibit behaviours that is perceived as different or embarrassing
- Is not helpful or cooperative, is rejecting or ungrateful and will accept care only from a particular person
- Has a difficulty in communication; for example through visual or hearing impairment,
- loss of or difficulty with speech, or a difficulty with memory and concentration

**Recording Assessment of Risk**

- It is vital to keep accurate records of discussions that take place about areas of choice and risk.
- Such documentation will be critical in order to protect the person in making their choices, as well as the position of the local authority, clinical commissioning group or private provider of care in the event of any complaints or litigation.
- The assessment and management of risk is a fundamental part of planning support for, and the safeguarding of adults at risk. As such it should be embedded in the assessment and support planning process from the start.
Completion of the Risk Assessment Tool

**Risk Identified**

- Working with the adult at risk and their carer where appropriate, identify what specific risks may be occurring at present or may occur in the future.
- Adults at Risk should be supported to identify the risks involved and devise ways of managing the risks.
- Identify the type of risk and its specific nature and context in this box.
- Some risk areas which workers may wish to consider, to prompt completion of this area of the form include: wandering, social isolation, mental health, medication, home conditions, diet, physical health, skin integrity, community concerns, relationships/carers, risks to others, mobility, finance, domestic abuse. This is not meant as an exhaustive list.

**Level of Risk**

When determining the level of the risk, assessors should consider the following:

- The vulnerability of the individual, for example; the extent of any cognitive impairment, level of physical or financial or emotional dependency, the ability to communicate and level of social and/or cultural isolation
- The nature and extent of the risk.
- The length of time over which the risk has been happening.
- The impact on the individual and on others
- Whether the situation can be monitored.
| **Low Risk** | An action which has an element of risk, but has been assessed as justifiable, with a low probability and which therefore should not prevent the action being carried out. |
| **Medium Risk** | Measured and controlled risk taking which empowers people to take risks in their day-to-day lives through the effective use of care planning. |
| **High Risk** | Action which is likely to result in injury to the individual, others or property. Where there is reason to believe that someone’s life may be in danger, that major injury or serious physical or mental ill health could result, that the incidents are increasing in severity or the behaviour is persistent and/or deliberate |

**Likelihood of the Outcome to Occur**

| **High** | Has already occurred or is very likely to occur. There may have been several recent incidents which suggest the outcome will happen imminently. The frequency of related incidents may be increasing. |
| **Medium** | Likely to occur; may have been some infrequent recent occurrences which suggest the outcome will happen |
| **Low** | May possibly occur; may not have been any recent occurrences, but there is evidence to suggest the outcome may happen |

**Benefits and Harms of Risk**

- The adult at risk should be at the heart of any discussions around benefits and harm of risks.
• Once a risk has been identified, it is important to consider the potential consequences of an action and the likelihood of any harm or benefit from it.

• It is important to remember that not all risk is negative. For example, an adult at risk remaining at home may be considered high risk, because of a number of factors. The positive outcomes of the risk of that person remaining at home could be increased choice and independence, retaining personal dignity and the right to private and family life.

**Adults at Risk Desired Outcome of taking the Risk**

• What is it that the service user wants to achieve by taking the risk?

**Adults at Risk Mental Capacity to make that Decision**

• Assessors should refer to the Mental Capacity Act 2005 for detailed guidance on assessing capacity.

• Practitioners in Derby City can seek operational support with the Mental Capacity Act from the Safeguarding Adults and Professional Standards Team. Practitioners in Derbyshire County can seek support from the MCA/DOLS Manager.

• All Adults at Risk are considered to have capacity to contribute and participate in a risk assessment. As such all practicable steps should be taken to ensure that Adults at Risk are put at the centre of the assessment and their views are recorded.

• Where there may be issues around the capacity of an individual to make choices and be involved in the risk assessment process, workers should consider completion of a Mental Capacity Assessment.
• Where an adult at risk’s capacity is called into question, it should be specifically related to one decision at that particular moment in time
• A separate Capacity Assessment record should be completed for each specific decision/risk
• For each risk identified, the assessor must document whether the service user has capacity to make a decision about that risk, and should select from the drop down list.
• Assessors should refer to the IMCA service where appropriate

**Is there any conflict identified?**

• Have there been any areas of conflict of opinion identified during the risk assessment?
• The needs and wishes of carers should be acknowledged and any conflict of opinion should be recorded.
• Conflict of opinion between practitioners should also be recorded.
• The conflict should be recorded as fully as possible.
• Record the name and relationship of the person with the conflicting view about the specific risk.

**Legal Powers and Duties considered**

• When considering risk, practitioners should explore the legislation that is available to be used, for example the Mental Health Act, the Mental Capacity Act, and the National Assistance Act, application to court of protection, Human Rights Act.
• Practitioners should also have in mind the common law "duty of care", and the importance of considering whether a person is incapacitated in making a decision as a result of constraint, coercion or other disabling circumstances
Protection Action Plan

- The action plan should enable people to manage identified risks and to live their lives in ways which best suit them.
- Adults at Risk should be supported to identify the things which can reduce harm and promote benefits.
- The risk management actions which are agreed by the adult at risk and worker should be targeted towards achieving specific outcomes.
- Inclusion in the risk assessment process is more likely to result in active participation and agreement with the action plan.
- Enabling people to exercise choice and control over their lives, and therefore the management of risk, is central to achieving better outcomes for adults at risk.
- Each action should identify who will be responsible for its completion and a date by which the action should be completed.

Review

- The risk assessment and action plan should be reviewed as required.
- The review date should be set and agreed with the adult at risk, but is not concrete, so if the situation changes sooner than the review due date, the risk assessment should be reviewed as soon as needed.
- The risk assessment process and action plan should be fluid and flexible. Things change all the time, and the risk assessment should be responsive to these changes.
- Practitioners should not do an assessment and leave it on file without reviewing its content and effectiveness with the adult at risk and other professionals involved.
- The form should be completed with the adult at risk, and should be signed by the adult at risk. This is to encourage openness and transparency, and to ensure that adults at risk are supported to participate in decision making.
- Forms should not be completed without the adult at risk or their representative being involved.
Section 9: Role of Other Services and Teams

**Care Staff and Service Providers**

Care staff will often be in close daily contact with Adults at risk. Their work and their relationship with people and their families give them a unique opportunity for identifying possible abuse. They need to be aware of their individual agencies' procedures and who to alert if they have any concerns. In addition providers play a crucial role in working with and monitoring risk situations.

Service Providers will not usually be included in the strategy meeting / discussion, if the alleged abuse concerns their service, particularly if there is a risk of contaminating evidence. They may be invited to part of a strategy meeting/ case conference and will only have minutes related to the part of the meeting they attend. When there is disciplinary action required against staff, Service Providers will be involved in the investigation as 'employers' under employment law.

**Complaints Teams**

Derby City Council and Derbyshire County Council both have statutory complaints procedures. If a complaint received by a complaints officer indicates that an Adult at Risk may be the subject of abuse, the complaints officer will make a referral at Stage Two of these procedures. The complainant should be informed of this course of action, unless this could jeopardise any subsequent investigation.

**Housing Organisations**

Housing workers may be the first to identify possible risk situations. In some circumstances alternative housing may be necessary to provide protection for the Adult at Risk. Housing staff are expected to be aware
of the indicators of abuse and to refer any concerns to Adult Safeguarding.

**Voluntary Organisations**

Voluntary agencies provide help and advice to a wide range of people who may be vulnerable and at risk. It is therefore essential that staff and volunteers know how to respond to incidents or suspicions of abuse and who to contact in the event of any concerns.
Section 10: Working with the Coroner

The Function and Purpose of the Coroner’s Court

The main function of the Coroner’s Court is to enquire into the death of a person within the Coroner’s Jurisdiction where there is reasonable cause to suspect that person has:

- Suffered a violent or unnatural death or;
- Suffered a death from an unknown cause or;
- Died in prison “whilst in custody or otherwise in state detention”. This includes individuals subject to an authorised Deprivation of Liberty,
- Died of trauma, injury or poisoning

The purpose of the inquest is to determine who the deceased was and how, when and where the person has died. The Coroner has an inquisitorial role conducting the proceedings and asking most of the questions. The Coroner will ask questions of all the witnesses under oath or affirmation. Any lawyers attending on behalf of the estate or family will be given the opportunity to ask questions regarding the cause of death.

The focus of the inquest is the cause of death and on matters relating to the cause of death. The Coroner’s inquest is not about apportioning blame.

Responsibilities in relation to Unexpected or Sudden Deaths

There are specific responsibilities in relation to a sudden or unexplained death in a care setting. This will also include a
person's own home where regulated services provide care and support.

If a person has died or is suspected to have died in any of the above circumstances the Care Provider must immediately call the Police. Staff must:

- Avoid touching the body (after ensuring there is no sign of life)
- Shut the door and leave the scene undisturbed
- Stay at the address until the Police arrive
- Notify the person’s GP
- Inform his/her line Manager
- Follow the Council’s Safeguarding Adults at Risk procedures if the death appears to have been a result of abuse or neglect
- Inform the Safeguarding Service Manager/ Contracts Manager at the Council and CQC if in a regulated setting.
- In cases where there are high concerns regarding the circumstances of a death and in extreme circumstances the Coroner can be contacted directly via Police Control Room.

Staff should check whether the GP or the Police will alert the Coroner’s Office about the death. The Manager of the care setting can also alert the Coroner on the next working day.

**Initial Investigation by the Coroner**

If the Coroner is notified about a death they will start an investigation. The Police become officers of the Coroner and may pursue any lines of Investigation as directed by the Coroner.

The circumstances of the death may have also invoked safeguarding procedures or, the adult at risk may have been subject to a safeguarding investigation prior to death, The coroner's office should be notified of the local authorities involvement. As a result, the
Coroner may ask for information from the Council in relation to the death. **Legal advice must be sought before any documentation is provided to the Coroner’s office.** This is to enable full consideration of the evidence requested to be undertaken.

In circumstances which involve the Council or its personnel the Council Solicitor should always be informed. Where a crime is suspected the Coroner will contact and inform the Council’s Director for Legal services directly of his views together with all the appropriate parties within the partner agencies.

If the Coroner is concerned that a person was unlawfully killed a referral will be made to the Police. If the Police think that there is a case to answer they may refer the matter to the Crown Prosecution Service. In this circumstance the inquest may be delayed.

**The Inquest Hearing**

The Coroner usually sits alone at the inquest, although a jury is required in cases where the death has taken place whilst the person was in state detention. This will include people detained in prison but also individuals who may be subject to an authorised Deprivation of Liberty, under the Mental Capacity Act (2005) or detained in hospital under the Mental Health Act (1983)

Inquests are open to the press and public to attend and usually take place in open court unless there is a matter for national security. Inquests which take place in Derby and Derbyshire are tape recorded and evidence heard and any submissions made are written down. The usual court rules regarding hearsay do not apply and the Coroner has the final say over what questions may or may not be asked. The Coroner also determines which witnesses will be called and the order in which they will be called. However, any party has the right to ask the Coroner to hear evidence from additional witnesses.
The Witnesses

Confirmation of the identity of the deceased person is required at the start of the proceedings. This is usually provided by a member of the family, or it could be provided by a doctor or nurse or someone else who knew the deceased person very well.

The Coroner will then usually call witnesses in an order that establishes a clear account, in sequence, of the events leading up to the person’s death. Witnesses can usually sit in an inquest from the start and must stay until released by the Coroner. They are required to swear an oath or affirm, and to identify themselves before any evidence is given.

Once each witness has given his/her evidence, the Coroner will ask any 'interested party' present whether they would like to ask questions. An interested party being an individual with personal interest in the case. The witness may then be asked questions by that interested party. This is most likely to be a family member or advocate appointed on their behalf about the cause of death, together with any legal representatives of interested parties.

Reports

Witnesses will almost always be asked to prepare a report prior to the inquest hearing. If council staff receive such a request the Council Adult Care solicitors must be contacted as soon as possible.

The statement/report must be concisely written and concentrate on the facts of the case, including accurate dates and times. It may be helpful to provide a chronology of involvement in a case stating the actions
taken, the date, by whom explaining the reason and outcome of the actions.

It is vital that original documentation is retained, as far as possible, as the Coroners office will require the submission of any original documentation to supplement reports. It is highly likely that copies of minutes of the safeguarding meetings that have taken place will be provided to the Coroner.

Writing good quality reports is dependent on keeping good records. Care must be taken with dates and times, and signatures on notes and letters must be legible. Copies of reports are likely to be shared with the deceased person’s family and the legal representatives of all interested parties.

It is important that, if called to give evidence, staff take time to prepare prior to the inquest. Staff should attend court in good time and take with them a copy of their statement/report and any relevant documentation or case notes.

**Giving Evidence**

The Coroner can call any staff member to attend the hearing who they feel has had a clear role in the case before them. The member of staff should inform their line manager – who will organise support via the legal team in Adult Care.

If you are asked to attend an inquest you must do so. The Coroner has the power to compel someone to attend and give evidence, produce documents, and make items available for inspection, examination and testing. Someone who does not comply or cooperate with such a notice or request can be fined or given a custodial sentence.
Summing Up & The Verdict

After considering all the evidence the Coroner will sum up and they will usually state in public the verdict they have reached. The following standard verdicts are available;

- Natural causes
- Industrial disease
- Dependence on drugs/non-dependent misuse of drugs
- Want of attention at birth
- Killed himself or herself (whilst the balance of the mind was disturbed)
- Accident/misadventure
- Killed lawfully
- Open verdict
- Killed unlawfully
- Narrative verdict

An open verdict may be returned where there is insufficient evidence to return any other verdict. The Coroner often makes a narrative verdict falling into none of the categories above but providing a short factual account of how the death came about.

The Coroner also has the power to require a report to be served under rule 43 of the Coroner's Rules 1984. They can write to a party reporting the circumstances of the case requiring that party to serve a report addressing certain issues which relate to remedial action being taken to prevent or reduce the risk of future deaths.

Other Court proceedings

If other Court proceedings are necessary these will normally follow the inquest. When all the facts about the cause of death are known, depending on the verdict, a person may be brought before another Court, or a claim for damages may be made.

**Reporting Concerns**

For staff who work in registered care settings where there has been a sudden or suspicious death it will be necessary to report to the following agencies where there are implications for the safety of others:

- Police
- CQC
- Adult Care Safeguarding Team
- DCC Contracts and Compliance
- Health & Safety Executive

The Coroner will refer any cases that meet the Safeguarding Adult criteria to the appropriate local authority Safeguarding Manager.

When there are circumstances which may pose a risk factor to other adults who are in a regulated care setting it may be necessary to have a safeguarding meeting to look at the risks and to minimise them.

If a referral is made by the Coroner and they feel that there may be a risk to others in a regulated care setting a safeguarding Strategy Meeting will be held to coordinate an investigation around the circumstances of the allegation and to consider the safety implications of other adults who may be at risk.

This process may also be occurring at the same time as a Police investigation who will become investigators for the Coroner.
SAFEGUARDING PROCEDURES & THE CORONERS INQUEST

STRATEGY MEETING

The Safeguarding Strategy Meeting Agenda should be followed for planning the investigation of the allegation. This would be followed by a case conference to ensure that any investigations are shared and actions taken within the remit of Derby and Derbyshire multi-agency Safeguarding Adults policy and procedures. The Police should be actively involved by contacting the Central Referral Unit.

It is worth noting that with consultation with the Police that other investigations/procedures may still follow or go side by side e.g. disciplinary procedures and Contractual Action Plans.

These meetings should also conclude with a protection plan to minimise the risks to others.

The social network of the deceased person should be involved if there is a Strategy Meeting directly involving the individual and given the option of being invited to that part of the meeting.

They would not participate in any discussion regarding other adults at risk.

The Chair will need to decide at the end of the case conference whether it will be appropriate to conclude the safeguarding process or proceed to a further case conference following further investigation, or awaiting outcome of the coroner’s inquest hearing.

ACTION PLAN FOR RISK TO OTHERS
Where the safeguarding refers to the safety of others in a group or domiciliary setting a further meeting may be required. In doing this reference should be made to the Care Provision Escalation Plan for Derbyshire. Any Action Plan arising from such a meeting may be of interest to a Coroner who will often want to know what actions have been taken by the Local Authority and others to address the safety of other adults who may be at risk.
Section 11 Commissioning and Safeguarding

**Commissioners of Services and Contract Monitoring**

Commissioners should ensure that all documents such as service specifications, invitations to tender and service contracts reflect the Safeguarding Adults Procedures and specify how they expect the service provider to meet the requirements of these procedures.

**Compliance with the Safeguarding Adults procedures will be included in the monitoring arrangements for contracts.**

Adult Social Care Staff will be responsible for notifying the relevant Contracts Team in the event of a Safeguarding referral concerning a contracted provider.

The contract manager responsible for the contract should attend any strategy or planning meetings concerning a contracted provider if required to do so, and carry out any actions agreed to at the meetings. They will then monitor to ensure that any changes required in the management, staffing or practices of the service are undertaken.

The performance management of care provision is the responsibility of care commissioners in Health and Adult Social Care. Recent Ombudsman’s judgements have gone against councils where they have failed to protect people in failing or poorly performing care homes. Commissioners are required to have robust procedures in place to deal with concerns and complaints, including safeguarding concerns.

The commissioners of care i.e. those Health and Social Care organisations who contribute financially towards the care of individuals, have a duty of care to ensure the care they purchase is of good quality and is safe and effective. They will make links with other organisations.
including Care Quality Commission, Care providers and other responsible bodies.

As commissioners for care services, the CCG and Adult Care take their duty of care very seriously and aim to engage in a positive and supportive way with all independent providers of care. There is now a jointly agreed Care Provision Escalation Plan for Derbyshire and a Safeguarding and Quality Care Provision in Derbyshire which has been signed by both Local authorities and the CCG in respect of dealing with concerns in relation to Contracted Providers. Please refer to the Adult Social Care website for a link to this policy.
Section 12: Guidelines for the Reporting of Accidents and Assaults to Adults at Risk

Reporting Accidents

Under The Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR, 1995) certain types of accident that occur ‘arising out of or in connection with work’ are ‘notifiable’ and reportable to the Health and Safety Executive (HSE).

From a safeguarding adult perspective, the types of accident which come under this category are:

- **Any person** who dies as a result of an accident arising out or in connection with work (employees, clients, members of the public, visitors to an establishment etc.).
- **Any person not at work** (client’s, members of the public, visitors to an establishment etc.) who suffers an injury as a result of an accident arising out of or in connection with work and that person is taken from the site of the accident to a hospital for treatment in respect of that injury.

‘Arising out of or in connection with work’, means that the accident has occurred because of something done or not done by the staff of an organisation carrying a work activity or because of a defect in the environment, which is controlled by the organisation. Please see below examples of reportable and non-reportable accidents under RIDDOR (1995):

- A person being hoisted using a sling with 6 loops, falls out of the sling due to one of the loops not being properly attached. - **Reportable**
- A resident in a care home is found on the floor with an injury which requires them to be taken directly to hospital after falling.
The fall was caused by the resident tripping over the edge of a worn carpet. – **Reportable**

- A resident in a care home is found on the floor with an injury which requires them to be taken directly to hospital after falling. The fall was caused by the person’s health or condition which meant they were unable to mobilise. – **Not reportable**

In Adult Care establishments, the process for reporting these types of incident is to contact the Adult Care Health and Safety (H&S) Section as soon as possible by telephone or e-mail, with details of the accident. The Adult Care H&S section will notify the Health and Safety Executive (HSE). A completed accident form will then need to be sent to the Adult Care H&S Section within 15 days. These forms can be found on the intranet, downloaded, completed by hand and then scanned and emailed to the relevant Principal H&S Officer, Derbyshire/Derby City Adult Care.

Where the work is being carried out by a private care provider or a voluntary organisation, it is that organisation’s responsibility to report incident to HSE.

**Definition of Assault**

**What is an assault?**
Any interaction between people which results in one or more of them **feeling** threatened.

For the purposes of reporting, the assault has to be an act of ‘non-consensual violence’ This is to differentiate between situations where the injured person agreed to the violent act taking place, such as professional sporting activities e.g. boxing.

An assault can be physical i.e. where a person is attacked by someone using a weapon or by the perpetrator using physical force (grabbing, punching, kicking, head-butting biting, scratching etc) or
Non-physical or verbal i.e. where the perpetrator shouts, swears or postures resulting in the victim feeling threatened although no physical contact actually takes place.
For the purposes of safeguarding, the following types of incident must be reported to H&S section.

1. Any assault that results in an injury to a client that results in them being taken directly to hospital for treatment.
   **NB these types of incident are also reportable as accidents so in addition to the assault form, the incident must be reported following the guidelines for reporting accidents above.**


It is important to note that any assaults will also need to be considered under the Derby and Derbyshire Multi-agency Adult Safeguarding Policy and Procedures, with reference to the Thresholds guidance.
Introduction

There are a number of health providers throughout Derbyshire and Derby City and these include:-

- Derby Royal Hospital Foundation Trust
- Derbyshire HealthCare Foundation Trust
- Derbyshire Health United
- East Midlands Ambulance Service
- Derbyshire Community Health Service
- Chesterfield Royal Hospital Foundation Trust
- Barlborough NHS Treatment Centre
- General Practitioners

Also included are the independent provider's dentists, optometrists, and pharmacists.

All these services are commissioned and quality assured by one of the following:-

- NHS Erewash Clinical Commissioning Group
- NHS South Derbyshire Clinical Commissioning Group (which includes the City)
- NHS North Derbyshire Clinical Commissioning Group (which includes High Peak excluding Glossop which is part of Tameside)
- NHS Hardwick Clinical Commissioning Group

Each Clinical Commissioning Group will have an Adult Safeguarding lead and a lead for the Mental Capacity Act. They will ensure that this
guidance is included in policies and training for all health professionals.

**Health focussed Assessments**

Health professionals will work in partnership with other agencies to safeguard adults at risk and investigate concerns of abuse or neglect. An adult safeguarding health focussed assessment can:

- identify the immediate, and medium term needs of the adult at risk
- establish that their treatment and care needs are being met
- identify safeguarding protection/safety plans for the adult at risk
- identify whether an urgent change of care setting is required

**Health focussed Investigations**

A health focused investigation into the treatment and care of an adult at risk should demonstrate:

- what treatment and care was delivered to meet the needs of the adult at risk
- whether there was an omission or commission of treatment and care to meet the needs of the adult at risk
- if professionals involved in the delivery of treatment and care knew what to do and whether they acted reasonably
- whether within the specific context the involved professionals took all reasonable actions to prevent the harm from occurring
- whether the consequences of the action or inaction could have been avoided, or, the risk of harm occurring could have been significantly reduced if alternative action had been taken

Where a health care professional is the investigator they will be responsible for assessing the health care needs of the adult(s) at risk,
both current and historic, and in relation to their present or previous care placement including hospital, care homes, residential nursing homes and community based care settings.

The investigating health practitioner can only give an opinion and write reports about areas where they have relevant professional knowledge and experience. The findings should be balanced objective and accurate. Assistance can be obtained from other health practitioners when needed, and specialist advice should be sought from the relevant service area when needed. The investigating health practitioner will complete a written report for the Local Authority Safeguarding lead/Safeguarding Manager detailing their opinion based on the available information as to whether, on a balance of probabilities, the abuse or neglect occurred.
Section 14: Involvement of the Social Worker

Social Workers

Derby City Council and Derbyshire County Council recognise the need for an effective and efficient investigative response achieved through working in partnership with other agencies. The Social Worker may be asked to work with other agencies to investigate concerns for example with a nurse from the area Clinical Commissioning Group (CCG). Throughout your practice and in particular during Safeguarding Procedures, you may be required to:

- investigate the circumstances that has caused abuse or neglect
- identify and assess the risk to Adult at risk
- support of the alleged victim/s
- support for perpetrators if they are identified as Adults at Risk
- liaise with other agencies
- provide evidence and reports
- attend strategy meetings, case conferences and court appearances.

Key Tasks

The key tasks undertaken by a Social Worker are summarised as:

- to participate in strategy discussions/meetings
- to undertake an investigation
- to effectively identify and manage risk
- to consider the protection of the individual and others
- to work in partnership with Adults at Risk and other agencies
- to work within the legislative framework e.g. Human Rights Act (1998), Data Protection Act (1998) etc.
• to consider and assess mental capacity under Mental Capacity Act (2005)
• to develop a safeguarding plan.

The investigating Social Worker will complete a written report for the Lead Manager/Principal Social Worker and will give an opinion based on the available information on a balance of probabilities, did abuse or neglect occur or not. Where abuse or neglect has occurred can the perpetrator be identified?

The report will contain:

• what the allegation was and what information is available
• what are the risks to the individual and what action has been taken to maximise their safety during the investigation
• the views of the Adult at Risk and views of other agencies/professionals
• recommended immediate actions to safeguarding the Adult at risk

The Social Worker will complete the following during the investigation when they are appropriate:

• establish if the Adult at risk has been seen in the previous 24 hours and where the Adult at risk has not been seen by a professional then arrangements will be made for the person to be visited by a professional for example a police officer or doctor
• make contact with the Adult at risk
• conduct sufficient enquiries to establish if abuse, exploitation or neglect has occurred based on a balance of probabilities
• identify the perpetrator
• inform the Derbyshire Constabulary Central Referral Unit on telephone number 101 or relevant Persons Susceptible to Harm Officer where there is:
  o any suspicion that the alleged abuse constitutes a criminal offence or
- there is a belief that a criminal offence has been committed or
- there is wider public safety issue the police need to be aware of and deal with

- instigate appropriate local and cross-agency checks to gather relevant information and establish whether the Adult at risk or the alleged perpetrator is known to any of the agencies and under what circumstances
- complete an assessment of capacity to make a specific decision at a particular time if appropriate, or commission a specialist assessment of capacity in respect of complex decisions except when required for a criminal court
- ensure that an advocate is appointed if necessary to represent the Adult at risk
- ensure that an Independent Mental Capacity Advocate is commissioned where the Adult at risk does not have the capacity to agree safeguarding measures and has no one else other than paid staff to represent them or where the relative or informal carer or person who normally speaks for the Adult at risk, is implicated in the allegation or the relative or informal carer requests the assistance of an IMCA. Friends or family could be considered inappropriate to consult if
  - they lack capacity
  - they are not available, perhaps as a result of geographical distance
  - they do not wish to be involved, perhaps as a consequence of relationship breakdown
  - there is tangible evidence that there may be a conflict of interest
  - they are implicated in the investigation
- ensure when assessing the Adult at risk needs that any support with parenting is taken into account
o seek consent from the family members to share information with other agencies in the best interests of the child. This should only be done if the discussion and agreement seeking will not place a child at increased risk of significant harm

o where a child is considered in need or at risk a referral is made to Childrens and Younger Adults department.

- consult with the Care Quality Commission if a regulated setting within the terms of the Care Standards Act 2000 is involved
- consult with the relevant agency Commissioning Department if a contracted service is involved
- where the Adult at risk is from another area, inform the Local Authority or CCG with responsibility for the Adult at risk, of the safeguarding concerns
- ensure that substance misuse problems are identified as part of the initial assessment
- a referral is made to the Derbyshire Fire and Rescue Service if appropriate where a fire safety check is needed
- a referral is made to the local area Independent Domestic Violence Advocates in relation to:
  - forced marriage
  - domestic Violence
  - sexual Violence
  - ‘honour’ based violence
  - harassment and stalking
- liaise with the Derbyshire Probation Trust where the Adult at risk or alleged perpetrator is supervised by the Derbyshire Probation Trust
- contact the Department of Work and Pensions where there are concerns financial abuse may be taking place
- make contact with a Deputy appointed by the Court of Protection to act on behalf of the Adult at risk and inform them of the referral
where it is appropriate and to obtain relevant information from them

- make contact with an Attorney acting on behalf of the Adult at risk and inform them of the referral where it is appropriate and to obtain additional information from them

- communicate with all other relevant parties / agencies as appropriate at this stage
Section 15: Involvement of the Derbyshire Constabulary

**Vulnerable Adults Central Referral Unit (V.A.C.R.U)**

The Vulnerable Adults Central Referral Unit is part of the Derbyshire Constabulary Public Protection Department. The VACRU should only be contacted where a crime has been committed or there is suspicion of a crime being committed.

When calling VACRU, staff members will be able to take details and record a new referral. This will then be passed to a police officer or suitable staff member for review. VACRU will call-back as soon as possible, in order to further discuss the referral. A Derby/Derbyshire Safeguarding referral form may be requested and this should be e-mail to vacru@derbyshire.pnn.police.uk.cjsm.net. It is important to use secure e-mail when exchanging confidential information with the Police. More serious referrals / incidents will be given priority. There is no need to wait to speak to a specific member of staff.

VACRU can be contacted, Monday-Friday 9am -5pm on **0300 122 8719** or **0300 122 4559**. If an adult safeguarding concern arises outside of these office hours, call the Police on the most appropriate number – either 101 or 999. Please advise the operator that the referral is a safeguarding matter regarding an adult at risk.

**Referral to the VACRU**

A referral to VACRU will see a 'Guardian Public Protection Record' created (GPP – the Police computer system of crime and intelligence recording). This will create a chronological record of any actions required / taken, discussions and decisions which take place and when.
Staff should make a note of the reference number to avoid delays in future communication.

The VACRU may decide that there is no criminal case to answer and therefore no role for the Police. They may still be able to provide advice and guidance for consideration as to what would bring the matter into the Police arena.

**If you are in any doubt that further information received may alter the stance of Police decisions please call VACRU for further discussion.**

If appropriate and proportionate the VACRU will carry out research on those involved in a case and consider whether information should or can be shared with other agencies.

### Possible Actions by the VACRU

If the referral concerns a serious assault, sexual assault, high value financial abuse or where a professional is involved then it will be referred to a Detective Inspector at the appropriate Division for consideration. Once the referral is allocated to a DI or an officer then the role of VACRU ends. VACRU will remain a point of contact if difficulties are encountered in contacting allocated officers.

Where a referral to a DI is not required but the referral requires immediate Police attendance then consideration will be given to creating a Police incident which will be attended by uniformed Police Officers in the first instance to deal with any immediate presenting threat to the Adult at Risk. A decision will then be made whether it remains with them or is allocated to other officers.

### Persons Susceptible to Harm (PSH)
Adults at Risk may well require services from the Local Authority and various agencies but may not meet the safeguarding threshold. These persons may still be susceptible to self-harm or may require an assessment for services or a review of services already received. It may be that they are living in the community in very poor circumstances, not taking medication or have a mental health issues and as a result they may be viewed by the Police as a Person Susceptible to Harm' (PSH).

Dedicated PSH officers will record on the Police Intelligence System types of incidents involving a PSH and will ensure appropriate agencies are alerted. PSH meetings are held at Division level and if warranted a referral will be made to VACRU for consideration of a safeguarding alert to adult social care.

**Where there is no Police role**

If having considered all the presenting information it is decided by Derbyshire Constabulary that there is no role for the Police, relevant advice will still be offered and the VACRU may be able to carry out research and share information to assist in a safeguarding investigation.
Section 16: The Mental Capacity Act (2005)


The Mental Capacity Act 2005 is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. This could be due to a mental health condition, a severe learning difficulty, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident.

The Act's purpose is:

- to allow adults to make as many decisions as they can for themselves
- to enable adults to make advance decisions about whether they would like future medical treatment
- to allow adults to appoint, in advance of losing mental capacity, another person to make decisions about personal welfare or property on their behalf at a future date
- to allow decisions concerning personal welfare or property and affairs to be made in the best interests of adults when they have not made any future plans and cannot make a decision at the time
- to ensure an NHS body or local authority will appoint an independent mental capacity advocate to support someone who cannot make a decision about serious medical treatment, or about hospital, care home or residential accommodation, when there are no family or friends to be consulted
- to provide protection against legal liability for carers who have honestly and reasonably sought to act in the person's best interests
- to provide clarity and safeguards around research in relation to those who lack capacity.
Principles of the Mental Capacity Act 2005

There are five guiding principles which should be borne in mind when working with the Mental Capacity Act, these are:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedoms of action.

Mental Capacity Act

The Mental Capacity Act states that a person is presumed to make their own decisions "unless all practical steps to help him (or her) to make a decision have been taken without success".

Every person should be presumed to be able to make their own decisions. You can only take a decision for someone else if all practical steps to help them to make a decision have been taken without success. For example, someone might have the capacity to walk into a shop and buy a CD but not go into an estate agent and purchase a property.

Incapacity is not based on the ability to make a wise or sensible decision.
Making a Decision on Capacity

To determine incapacity you will need to consider whether the person being looked after is able to understand the particular issues that the decision is being made about. You need to consider if they have:

- an impairment or disturbance in the functioning of the mind or brain, and
- an inability to make decisions.

A person is unable to make a decision if they cannot:

- understand the information relevant to the decision,
- retain that information,
- use or weigh that information as part of the process of making the decision, or
- communicate the decision.

Making a Decision for Someone

If, having taken all practical steps to assist someone, it is concluded that a decision should be made for them, that decision must be made in that person's best interests. You must also consider whether there's another way of making the decision which might not affect the person's rights and freedoms of action as much (known as the 'least restrictive alternative' principle).

Best Interest Decisions

Section 4 of the Mental Capacity Act (2005) sets out a checklist of things to consider when deciding what's in a person's best interests. You should:

- not make assumptions on the basis of age, appearance, condition
or behaviour

- consider all the relevant circumstances
- consider whether or when the person will have capacity to make the decision
- support the person's participation in any acts or decisions made for them
- not make a decision about life-sustaining treatment "motivated by a desire to bring about his (or her) death"
- consider the person's expressed wishes and feelings, beliefs and values
- take into account the views of others with an interest in the person's welfare, their carers and those appointed to act on their behalf

For further advice and guidance on issues related to the Mental Capacity Act, please refer to the Codes of Practice which can be found at:  http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf
Vulnerable Adults who are Perpetrators

Alleged perpetrators may also be Adults at Risk, in that they may have age related frailty, physical disabilities, learning disabilities or mental ill health.

Where the alleged perpetrator is an Adult at Risk it is important that:

- Agencies fulfil their responsibilities towards the alleged perpetrator as well as the alleged victim including involving the Police is required.
- Information about their involvement in a Safeguarding Adult investigation, including the outcome of the investigation, should be included on their case records.
- If a risk assessment concludes that the alleged perpetrator continues to pose a threat to other service users, then the safeguarding strategy and protection plan should address the needs of the perpetrator and the management of the risks to other Adults at Risk, providers of services and the public.

Alleged perpetrators that are identified as Adults at Risk, who need to be interviewed by the police should be assured of their right to the support of a trained 'Appropriate Adult' whilst they are being questioned by the police under the Police and Criminal Evidence Act 1984 (PACE). It is not appropriate for untrained staff/volunteers to take the part of an appropriate adult. Derbyshire Advocacy run the Derbyshire Appropriate Adult Service which covers both the city and county. This service will be contacted by the allocated police officer.

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What is the Derbyshire Appropriate Adult Service?

The Derbyshire Appropriate Adult Service (DAAS) have provided the following information about their service. DAAS provides trained volunteers to act as 'Appropriate Adults' in all police custody suites throughout Derbyshire in compliance with the Police and Criminal Evidence Act (PACE) 1984, Codes of Practices.

The role of the Appropriate Adult service is to ensure:

- all vulnerable adults and young people are supported and that their rights and entitlements are met whilst in custody
- a person’s welfare needs are met and that the person understands right to free independent legal advice.
- that all interviews are conducted fairly
- good communication with detained person of all procedures to be carried out and reduce anxiety and distress where possible.
- good communication between police, solicitors, health professionals on detained persons behalf.

An Appropriate adult (AA) should always be present at the PACE interview and witness all other procedures in accordance with the Codes of Practice.

What does the AA service offer?

- Attend any police custody suite throughout Derbyshire on request from the police, solicitors, social workers, care staff or health professionals.
- Visit Prisons for further interviews on request from police.
- Attend calls in private homes for RSPCA interviews under PACE.
- Attend Benefit Fraud interviews if under PACE conditions.
- Voluntary Interviews in Police stations under PACE conditions.
- Attend any location with a detained person under PACE conditions i.e. scenes of crime, hospitals etc.

**Who does the AA service work with?**

- People defined as vulnerable in PACE.
- Juveniles
- People with a Mental Illness
- People with a Learning Disability
- People who cannot read or write
- People with Dyslexia
- People with sensory impairments Hearing/Sight (Signers and other services used appropriate)
- People who’s first language is not English and are vulnerable with any of the categories above (interpreters are used to cover the specific language requirements)

**What ages does the AA service work with?**

- Juveniles 10 years to 17 years in the county of Derbyshire (Not Derby City)
- Adults 17 years onwards.

**What hours does the AA service work?**

Service starts each day 8am to 12 midnight 365 days a year.

**What doesn’t the AA service do?**

- The Appropriate Adult service only attends alleged offenders.
- Derbyshire Appropriate Adult Service does not attend witness or victim statements. (This is covered by the local authorities vulnerable witness provision.)
Contact details of Derbyshire AA Service

Main Office - 01332-206505
MAPPA stands for Multi Agency Public Protection Arrangements. Established in England and Wales since 2001, the arrangements serve to identify, assess and manage the risks of re-offending and harm posed by certain sexual, violent and other dangerous offenders. The value of the arrangements lies in partnership, through which the agencies involved can together achieve results which help to make communities safer.

In Derby and Derbyshire the arrangements bring together Derbyshire Constabulary, the Derbyshire Probation Trust and HM Prison Service (East Midlands Area) into what is known as the MAPPA ‘Responsible Authority’. A number of other services and agencies have a ‘duty to co-operate’ with the Responsible Authority through the arrangements. These co-operating partners include:

- Derby City and Derbyshire County Youth Offending Services.
- Derby City and Derbyshire County Children’s and Adult Social Care Services and Education services.
- Derbyshire Healthcare NHS Foundation Trust and other health providers.
- Derby City and the Derbyshire District Authorities Housing Services, and certain registered social housing providers.
- Jobcentre Plus (Department for Work and Pensions).
- Electronic monitoring (‘tagging’) providers.
- The UK Border Agency.

### MAPPA Categories

There are three categories of MAPPA offender:
Category 1: Registered Sexual Offenders
These are sexual offenders, who as a result of a conviction or caution for a relevant offence, are required to notify the police of their name, address, and other personal details, and also notify any subsequent changes. Registration periods are fixed by law, and can last from 12 months to life depending upon the offender's age at the time of the offence, the age of their victims, and the nature of the offence or type of sentence imposed. These offenders remain within MAPPA until the registration ends.

Category 2: Violent and Other Sexual Offenders
These offenders have been sentenced to imprisonment or detention for 12 months or more, or have been detained under a Hospital Order, for murder or one of a wide range of other serious violent offences. The category also includes a small number of sexual offenders who do not qualify for registration, and offenders disqualified by a court from working with children. Offenders in this category are included under MAPPA until the end of their sentence or licence or order.

Category 3: Other Dangerous Offenders
This category contains offenders who do not meet the criteria for either Category 1 or Category 2 but who are considered by the Responsible Authority to pose a risk of serious harm to the public which requires active multi-agency management. To register a Category 3 offender, the Responsible Authority must establish that the person has committed an offence which indicates that he or she is capable of causing serious harm to the public, and must reasonably consider that the offender may cause serious harm to the public which requires a multi-agency approach at level 2 or 3 to manage the risks. The person must have been convicted of an offence, or have received a formal caution or
reprimand / warning (young offenders). Offenders convicted abroad could qualify for Category 3.

Offenders considered in the first two categories are always included under the Arrangements until the end of their sentence, disqualification, or registration period. The third category is included only when it is agreed that an offender should be managed at MAPPA Levels 2 or 3, and ends when they are discharged from joint management.

**MAPPA Levels**

MAPPA offenders are managed at one of three levels according to the extent of agency involvement needed and the number of different agencies involved. The great majority are managed at level 1 (ordinary agency management). This involves the sharing of information but does not require multi-agency meetings.

**Level 1: Ordinary Agency Management**

Offenders managed at level 1 are subject to the standard arrangements applied by whichever agency is supervising or managing them. Management at this level can still involve information sharing and liaison between partner agencies. For example, regular information exchange meetings take place between the Police and Probation Service on high risk registered sex offenders who are not managed at levels 2 or 3.

**Level 2: Active Multi Agency Management**

The risk management plans for offenders at this level require the continuing active involvement of several agencies, co-ordinated through regular MAPPA meetings. Comprising core representatives and other agency workers, regular monthly meetings take place across Derby and Derbyshire, usually at Probation or YOS offices.
Level 3: Active Enhanced Multi Agency Management

Needing co-ordinated management, as at Level 2, these cases additionally require the active involvement of senior officers/managers who can identify or authorise extra resources, such as police surveillance or specialised accommodation, or provide ongoing senior management oversight. This may apply to certain cases that raise major public interest or concern. An Area Level 3 meeting is held every month at Derbyshire Police HQ, and at other times, if needed.

At each level the aim is to make sure that all reasonable steps are being taken to keep to a minimum the offender’s risk of re-offending and causing further serious harm. Management normally takes place at the lowest level at which this can be achieved. Though more likely to call for an active multi agency approach higher risk cases can be managed at any level, including Level 1 where this is sufficient, or only one agency is involved. Likewise, in some circumstances, a lower risk case might merit referral to Level 2 or 3.

Disclosure

If an offender poses a significant risk of harm and members of the public need to be protected, information can be given to community organisations, faith groups, families or individuals, as relevant.

The protection of members of the public counts for more in these situations than an offender's right to privacy.

Further Information

Version 4 of the national guidance was released in May 2012 and is available online at http://www.justice.gov.uk/offenders/multi-agency-public-protection-arrangements
Why and How are Investigations carried out

The purpose of any investigation is to:

- Protect the adult at risk from serious harm and offer them support
- Establish and record the facts about the circumstances giving rise to the alert
- Establish evidence for formal proceedings (e.g. criminal, registration or disciplinary)
- Establish with the adult at risk whether they feel that their personal safety is at risk, whether they want professional intervention to occur and what their views are on sharing information about the incident with other staff that need to know
- Decide if protective or other action is needed for the adult at risk or others
- Identify the sources and levels of risk
- Decide whether actual or suspected abuse has taken place and record the reasons for these conclusions
- Ensure that appropriate action is taken in respect of any perpetrator
- Identify any lessons to be learnt for the future, including recommending changes to existing practices or service delivery

The tasks that need to be undertaken will include the following:

- Carry out a comprehensive assessment
- Assess the mental capacity of the adult
- Determine the need for medical intervention relating to the physical, or mental, state of the adult at risk
- Liaison with the police
- Decide whether legal advice needs to be sought
- Ascertain the need for a Case Conference
• Consider the different methods of gathering and presenting evidence
• Consider the communication needs of the adult at risk and ensure that an appropriate service is offered (this includes people with dementia, those whose first language is not English, people with sensory impairment, people who have learning difficulties or people with acute mental health issues)

It is important that information is shared throughout the investigation process. This will include keeping the alert, or referring agency, appropriately informed of progress and likely timescales for decisions and outcomes, within the principles of information sharing (see Information Sharing section of this practice guidance for more information.)

Planning the Investigation

Consideration of the following points is important to inform the decision-making process and the way in which the investigation should be planned?

• Who should be interviewed?
• What support is needed for when interviews take place?
• The available sources of evidence which could include written records, statements from witnesses, forensic and medical evidence
• Where will be interviews take place
• The sequence of interviews
• Who will conduct the interviews?
• The need for medical examinations
• The degree of risk to the adult at risk, including:
  ➢ The risk of repeated or escalating acts
  ➢ The extent of the abuse
The length of time that the abuse has been occurring
- The impact upon the individual
- The urgency of the situation and whether immediate action is needed
- The rights and wishes of the people involved
- The legal framework under which the investigation will pursued

Consideration should be given to whether alerting the person alleged to have carried out the abuse might further jeopardise the safety of the adult at risk, or the collection of evidence. At this stage it may be useful to seek legal advice about the involvement of the perpetrator.

Decisions about who should be informed about the alleged abuse need to be made; in particular any agencies involved with the adult at risk. It will be appropriate, usually, to inform a family member should the adult at risk consent.

The reasons for decisions being taken, or not taken, must be recorded.

If the person allegedly responsible for the abuse is also an adult at risk then the investigation should ensure an assessment of their needs is also undertaken. In this instance a separate Case Conference may need to be convened.

**Who Might be Involved**

The investigation may have several strands, all of which require careful co-ordination. This co-ordination should take place at the strategy / discussion meeting stage.

Police: the police investigation considers whether a crime has been committed. The police will not lead a multi-agency Safeguarding Adults
Investigation, however where criminal offences are suspected, criminal investigations must have primacy over other enquiries. The police will work closely with adult social care services and other relevant agencies to ensure that the welfare and care of adults in need of safeguarding is considered while ensuring that nothing is done in any other part of the investigative process that could interfere with the criminal investigation.

In order to prosecute there must be sufficient evidence that an offence has been committed 'beyond all reasonable doubt.' Insufficient evidence to support a prosecution does not mean that there may not be steps that need to be taken in response to the alleged abuse to protect the alleged victims/s. These steps may include:

- Action by Care Quality Commission (CQC)
- Disciplinary action by employers
- Legal Actions
- Action by contracts department

**Contracts Department:** A contracts department will investigate any breaches in the contractual arrangements made with a provider. They may also need to liaise with contracts departments with other local authorities or health trusts as appropriate.

**Care Quality Commission (CQC):** The CQC will investigate allegations concerning the standards of care provided by a registered health or social care service provider. CQC and works with the provider to ensure safe working practices and improved standards to ensure continuing protection for the alleged victim and adults who may be affected. Where improvements are not made the CQC has powers to take certain actions, including enforcement against the registered manager/provider.

**Disciplinary Investigation:** The disciplinary investigation will be led by the employing agency following their own internal disciplinary
procedures. It will ascertain whether the staff member has been guilty of misconduct or gross misconduct in the course of his or her duties. As well as the allegation of abuse the disciplinary investigation will also consider whether a referral to the Disclosure and Barring Service is required.

Adult Social Care Services/ Health Service Led Investigation: They will make an assessment of actions necessary to ensure continuing protection for the alleged victim and any other adults who may be affected. Decisions will be based on professional judgement of the information presented.

**Investigator’s Interviews**

The adult at risk should not be interviewed alone or in the presence of the person alleged to be responsible for the abuse, after the first disclosure or alert, if there is any possibility that an offence may have been committed. In such cases a joint interview is preferable at which the adult at risk may be accompanied by any, or several of the following:

- An independent advocate
- A family carer,
- Member of their family,
- Close friend,
- Supporter or
- Person of the Adult at Risk’s choice

Care should be taken to ensure that a premature determination of abuse does not occur. No plan of action, except in emergency circumstances, should be initiated until the facts surrounding the alleged abuse have been established.
Carrying out an Interview

During the interview the Investigating Officer should ensure that:

- Information about their designation and the agency represented is stated clearly
- The purpose of the interview is made clear
- The nature of the allegation is identified
- How the interview is carried out is explained
- How the interview will be recorded and for what purposes
- A relaxed and caring manner is adopted
- An attempt is made to establish how the alleged abuse occurred
- Suitable breaks are agreed and adhered to

Investigation Evidence

The investigation will consider:

- Was / is the situation abusive
- Is this an isolated concern, or have similar concerns / complaints been expressed previously
- What evidence / indicators are there
- What facts can be established about what happened, when and by whom
- How long has the situation been going on
- How does the alleged victim perceive the alleged abuse
- What is the victim’s mental capacity to make specific decisions
- How does the alleged perpetrator perceive the alleged abuse
- What action does the alleged victim wish to see taken regarding the alleged abuse
- Could the alleged victims decision and action have been unreasonably influenced by someone else
- What is the impact to the victim
• What are the rights and wishes of those involved
• What is the legal context
• Have there been any breaches of contract or regulation
• What could have been done to prevent the abuse occurring
• Staffing issues
• Review of policy / procedure / practice

**InVESTIGATOR’S REPORT**

The report will need to cover the following areas:

• Details of the initial alert
• Outline of the current and any previous allegations
• An assessment of the seriousness of the abuse
• Possible causal factors
• Background information about the adult at risk
• Issues and opinions relating to consent and capacity
• Information about the alleged perpetrator
• A description of the Investigation process (what was involved) and the level of co-operation received from those consulted
• Presentation and evaluation of evidence
• A view about current and future risks and plans to manage those risks
• Recommendations about future action and rationale for this (protection/ safety planning)

**Large-Scale/ Institution-Wide Investigations**

In addition to this guidance regarding all investigations, there may be additional considerations required in large scale / institution-wide investigations
Whenever abuse is alleged or suspected, it is important to consider whether any other adults in need of safeguarding, could be at risk.

The need for a large-scale investigation is evident where it is suspected that a number of adults in need of safeguarding have been abused:

- In the same setting
- By the same perpetrator
- By a group of perpetrators

In all multi-agency investigations, there will be a variety of agencies involved and the investigative process may comprise of several individual investigations. Within a large-scale investigation, this will certainly be case and it is imperative that a strategy meeting / discussion should be held among all agencies at the earliest possible time.

**It is recommended that this be an actual meeting rather than simply phone or email contact, given the number of organisations who may be involved and the need for clarity on the role of each agency / professional.**

The strategy meeting may need to consider the following issues in addition to standard procedure:

- Immediate safety of all individuals involved. This may include the need to suspend or relocate a number of staff. Arrangements may need to be made for alternative accommodation or care provision for a number of individuals
- Agree who may need to be involved such as CQC, contracts departments and / or other local authorities and Health Trusts
- Agree how best to co-ordinate the investigation and who has overall responsibility for co-ordination and chairing of any subsequent meetings
- Agree roles and responsibilities of each agency and individuals involved and ensure that all are aware of how their part in the investigation fits in to the overall multi-agency process
- Decide who needs to be notified of the investigation, who is best placed to do this and how it should be done. Those who need to be notified include senior management, organisational Safeguarding Adults leads, legal services, elected members, family and relatives of those adults who may be at risk
- Consider resource implications around the number of investigators needed, the facilities for conducting the interviews, funding to re-locate individuals at risk etc.
- Consider how to support that alleged victim/s and their family / carers through the process and following conclusion, including the possibility of advocacy services, support groups etc.
- It may be useful to have in mind a checklist of questions appropriate to the particular case details (see question phase for advice on types of questions to use)

Further information can be found in the Commissioning and Safeguarding section of this practice guidance.

**Closing the Investigation**

Prior to closing an investigation the Investigating Officer should ensure that:

- All verbal and written records have been completed
- The case file contains all the necessary information and forms
• Agencies who are involved in the Adult Protection/Safety Plan are aware of their responsibility to re-refer the adult at risk should circumstances change or risks increase
• Adult Protection/Safety Plan has been implemented
• All decisions have been recorded in writing with evidence to support the decisions clearly documented
• The reasons for closing the investigation are fully recorded

Once the investigation has been completed, there should be clarity about whether on the balance of probabilities, abuse has taken place. Any decisions regarding case closure should be agreed and fully recorded. Cases can be closed at any stage of the investigation with the agreement of the agencies involved. The decision should detail any investigation with the agreement of the agencies involved. The decision should detail any interventions put in place in respect of both the victim and the perpetrator.

Prior to closing an investigation there should be regard to the following:

• The reason for closure must be agreed and the decision must be recorded explaining the judgement, reason and defensible decision for the actions taken
• The case file must contain all the necessary information, minutes, forms and reports
• A decision should be made on how the information is to be shared with the adult at risk of abuse
• All decisions should be recorded and be defensible
• The adult at risk and their family views carers’ (if appropriate) of the outcome and process are recorded
• The adult at risk is fully informed and aware of the details of the safeguarding plan and review process
• Consideration must be given as to whether any staff, alerter, whistleblower, carers need additional support.
Definitions of Safeguarding Conclusions

Safeguarding conclusions are drawn on the balance of probabilities. This means that when reaching a decision, the evidence suggests that the abuse was more likely to have occurred than not.

**Substantiated – fully:** This refers to cases where “on the balance of probabilities” it was concluded that all the allegations made against the individual or organisation believed to be the source of the harm or neglect were proved. Where allegations of multiple types of abuse are being considered against an individual or organisation then all will need to be proved for it to be defined as fully substantiated.

**Substantiated – partially:** This refers to cases where there are allegations of multiple types of abuse being considered against an individual or organisation. Verification will be partial where “on the balance of probabilities” it was concluded that one or more, but not all, of the alleged types of abuse were proved. For example, a referral that includes allegations of physical abuse and neglect, where the physical abuse can be proved on the balance of probabilities, but there is not enough evidence to support the allegation of neglect will be partially substantiated.

**Inconclusive:** This refers to cases where there is insufficient evidence to allow a conclusion to be reached. This will include cases where, for example, the individual subject to the referral, the individual believed to be the source of the risk or a key witness passed away before they could provide statements as part of the assessment or investigation.

**Not-substantiated:** This refers to cases where “on the balance of probabilities” the allegations are unfounded, unsupported or disproved.
**Investigation ceased at individual’s request:** This refers to cases where the individual at risk does not wish for an investigation to proceed for whatever reason and so preclude a conclusion being reached. Referrals which proceed despite this, for example where a local authority has duty of care to protect other residents in a care home setting or multiple individuals in supported housing, will not come under this definition.
What is MARAC?

MARAC is the abbreviation for Multi Agency Risk Assessment Conference. It is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic abuse. Agencies involved include; Police, Health, Child Protection, Housing, Fire Services Independent Domestic Violence Advisers, Adult Social Care, Mental Health, Probation, Drug & Alcohol Advisors as well as other specialists from statutory and voluntary sectors.

The process ensures that there is a sharing of information and an action plan is discussed so that each agency can ensure they have an appropriate risk and safety plan in place. Usually there is no follow up by MARAC after this meeting, so it is important each agency completes its own agreed actions.

Referrals into MARAC

If a person is referred into Adult Care and is experiencing domestic abuse, stalking or "honour-based" violence, consideration should be given to the MARAC process. Ideally there will be a discussion with the person to gain their consent to do the risk assessment and make the referral. The risk assessment and referral forms should be completed with the person. However, where the situation is high risk, lack of consent can be overruled and a referral made to MARAC if appropriate. Consent and/or reasons for overriding consent should be documented on the person's care records.

Workers should complete a Risk Assessment on the MARAC CAADA DASH checklist form. If the risk assessment identifies 14 yes answers
this means that the threshold has been met to complete a MARAC referral. However, if a case does not meet the threshold for referral, but is high risk and there are a mixture of "yes" and "don't know" responses, workers should use professional discretion about whether to send a referral to MARAC. If the person is identified as not at high risk of harm then they can be referred to other support services across the City and County, see www.saferderbyshire.gov.uk for more information.

If a referral to MARAC is appropriate, workers should complete the joint MARAC and IDVA referral form. This form should be sent by secure email to MARAC@derbyshire.pnn.police.uk.cjsm.net. In addition, the form should also be sent by secure email to the relevant area Independent Domestic Violence Advocate (IDVA) service. For County cases this is idva.team@ndwa.cjsm.net or sharon.ryan@bolsover.gcsx.gov.uk for Bolsover, and for City cases this is family.justicecentre@derby.gov.uk.cjsm.net. A guide on how to refer to MARAC can be found on the following link www.saferderbyshire.gov.uk. Alternatively advice can be sought from the Safeguarding Team within Adult Care or the Domestic Violence Service Manager in Derbyshire County Council.

It may be that the person is also referred into safeguarding. If so, a referral to MARAC will automatically be considered under the Strategy Meeting Agenda.

When a referral is received by the MARAC co-ordinator, if the referral is appropriate and complete, the person will be put on to the list for the next MARAC meeting.

**General principles of information sharing relating to MARAC**

1. All attendees at MARAC Meetings must understand their responsibilities – a statement should be read out at the start of
each MARAC reminding participants of their ethical and legal responsibilities.

2. Normally victims are told that they are to be referred to MARAC, what that means and that a referral will be made to the IDVA (Independent Domestic Violence Adviser) service who will offer them one to one support.

3. Consent should be asked for, however it is not necessary, as the decision will already have been taken that a MARAC is needed, based on the risk to the victim. If the victim does not engage and does not agree to the referral, the MARAC will still go ahead although its effectiveness may be reduced.

4. There should normally be transparency around the process of the victim's information and potentially that of their children (if any) being shared – unless this would itself increase the risk of harm.

5. Furthermore, the alleged perpetrator should not be asked for their consent or informed about the MARAC referral as to do so might jeopardise the victim's safety.

6. Information sharing about both the victims and perpetrators is shared in the context of sharing without consent for the prevention and detection of crime or serious harm.

7. MARAC representatives should be reminded that although the process is victim focussed, the rights and humanity of the perpetrator also need to be recognised and addressed. The perpetrator may need the support and engagement of multiple agencies in addressing their own needs in relation to mental health, drug or alcohol abuse, housing or other issues.

8. In addition to the risks posed to the victim, information shared at MARACs can raise significant issues to public safety, where for example a perpetrator is threatening to kill either their family or others. Some information on alleged perpetrators may justify alert 'flagging' on information systems in order to protect staff.
Specific guidance for Health staff

It will be helpful for health representatives to have triaged, in advance, the information they have available to share, but they should not share information until they are convinced that it is justified to do so.

Health information is often particularly sensitive and it is therefore suggested that it should be held back until other agencies have shared sufficient information for the health representative to conclude that sharing is indeed justified and proportionate. For example, the fact that a woman has had repeat attendances at A&E might not be disclosed at MARAC unless another agency brought information to the MARAC that indicated that these were directly or indirectly as a result of violence from the alleged perpetrator.

The decision on whether and what to share therefore requires appropriate consideration, as the decision to share will often be context dependent. **Even when there is a clear justification to disclose some information staff should apply the Caldicott Principle of ‘sharing the minimum amount of information’**.

Decisions to disclose must be properly documented immediately, identifying the reasons why the disclosures are being made (i.e. what risk is believed to exist), what information will be disclosed and what restrictions on use of the disclosed information will be placed on its recipients.

Specific information for Adult Care staff

It is expected that a Service Manager or Principal Social Worker/ Senior Practitioner will attend the MARAC meeting and that details of the perpetrator, victim and any children will be provided. Information will only be shared on people who receive a service from Adult Care.
Any details regarding the victim or perpetrator can be shared in line with the information sharing agreements which are signed up to in the MARAC process.

It is likely that the majority of people will not receive a service from Adult Care.
When a person is known it may be necessary to consider the use of Adult Safeguarding Procedures if we are not already aware of this, and this may be an action or outcome of the MARAC process.

Sometimes within the MARAC process information is shared regarding a person who may be an employee within a care setting. If this person poses a risk to others this will need to be shared with a manager to discuss if any information is required to be shared with an employer.
Section 20: The Role of an IMCA

What is an IMCA

Under the Mental Capacity Act 2005, there are circumstances where a person who lacks capacity is entitled to the support of an Independent Mental Capacity Advocate (IMCA).

The purpose of the IMCA is to represent vulnerable people who lack capacity to make important decisions where they have no family and friends available for consultation about those decisions.

The role of an IMCA can be divided into two main parts:

1) the traditional advocacy role of supporting and representing a person's wishes and feelings so that they will fully be taken into account; and
2) the new role of providing assistance for challenging the decision makers when the person has no one else to do this on their behalf

Who Qualifies for the IMCA Service?

Individuals who:

- Lack Capacity in relation to certain specific important decisions as outlined below and
- Have no-one close to them whom it would be practical or appropriate to consult, other than paid workers, and
- Have not previously named someone who could help with a decision and
- Have not made a Lasting Power of Attorney or Enduring Power of Attorney unless the attorney or deputy has been appointed solely to deal with the person's property and financial affairs
In Adult Safeguarding cases, an IMCA may be appointed even where there are family members or others available to be consulted.

**Which decisions MUST involve the IMCA service?**

**Serious medical treatment** - Decisions about providing, withholding or stopping serious medical treatment. The only exceptions are where the proposed treatment needs to be provided as a matter of urgency or where treatment is provided for mental disorders under the Mental Health Act 1983.

**Decisions about long term care moves** - Proposals to move a person into long term care in a hospital (for more than 28 days) or a care home (for more than 8 weeks) or a long term move to a different hospital or care home. The only exceptions are where the placement or move needs to be made as a matter of urgency or in situations covered by the Mental Health Act 1983.

**Which decisions MAY involve an IMCA?**

**Care Reviews** - Where the responsible body has arranged the original accommodation for the person lacking capacity, they intend to review these arrangements and there are no family or friends to consult, they may instruct an IMCA if it is felt that this would be of particular benefit to the person.

**Adult Safeguarding Cases** – Where an allegation has been made that the person lacking capacity is being or has been abused or neglected by another person, or the person is abusing or has abused another person, an IMCA may be instructed if it is felt that this would be of particular benefit to the person.
**When to consider an IMCA for Safeguarding Adults Cases**

If you can answer ‘yes’ to all of the following statements then instructing an IMCA must be considered:

- Safeguarding procedures have been instigated
- Local Authority or NHS body proposes to take, or has taken, protective measures
- Person has been assessed as lacking capacity to agree to one or more protective measures
- It will be of “particular benefit” to the person to have an IMCA involved

It is a complex case

**What is meant by complex case for IMCA involvement?**

1. There is a serious exposure to risk, for example; death, serious physical injury or illness
2. A life-changing decision is involved
3. There is a conflict of views regarding the best interests of the person particularly within the family or views of important others. This may be where a Deprivation of Liberty is in place restricting contact with the significant others and this is being challenged.
4. The likelihood that the safeguarding case will progress to the Court of Protection.
5. There is a risk of financial abuse which could have a **serious impact** on the person’s welfare, for example, where the loss of money would mean they would be unable to afford to live in their current accommodation, or to pay for valued opportunities.

**At What Stage in the Process Should an IMCA be Instructed?**

**The Strategy Meeting stage**
In some cases it will be appropriate to involve an IMCA at this stage. For example, where the wishes/decisions made by the individual would have a significant impact on the investigative process or where immediate actions need to be taken to safeguard the individual prior to further investigation taking place. The IMCA may be a crucial link to the significant others where there is conflict. However it is the role of the social care worker to inform the significant others / family that the person is under safeguarding procedures, not the IMCA.

The IMCA can access a wide source of information and may be crucial to gathering information within the safeguarding process in order to develop a view regarding a best interest decision.

Any risks identified with the members of the family/significant others should be identified and shared with the IMCA.

**The Case Conference stage**

There may be a number of case conferences within the safeguarding process particularly where there are complex issues which require consultation with a number of interested parties.

The IMCA role may be to consult with a variety of significant others and to contribute to a “best interest decision” on behalf of the Adult at Risk. It is important to remember that the IMCA's report is focused on the Adult at Risk whom lacks capacity and as such is independent of any statutory agency. They can challenge the role of the local authority / agencies if they feel this is not in accordance with procedure or in the best interests of the individual.

The Court of Protection will take into consideration the views of the IMCA where a person lacks capacity and there is a conflict of interest regarding the safeguarding decisions of a vulnerable adult.
Who Can Instruct an IMCA?

An authorised representative of the Local Authority or NHS Body that may need to take protective measures, for example this may be the safeguarding manager or a Social Care Worker.

This person will inform anyone who needs to be aware of the safeguarding adults proceedings that an IMCA has been instructed. This may include family or friends.

How to Instruct an IMCA

A referral form can be downloaded at www.derbyshireimca.org.uk. These can be faxed to 01332 293884.

In Adult Safeguarding cases, the IMCA will require a completed IMCA referral form and copies of the safeguarding referral form, strategy meeting minutes and any reports produced as part of the Adult Safeguarding proceedings. Once an IMCA has been instructed they should be invited to all safeguarding meetings.

The Role of an IMCA in Safeguarding Adults Cases

- To represent and support the person in relation to decisions concerning protective measures (including decisions not to take protective measures).
- To ensure all possible protective measures have been considered
- To ensure the person has been given as much support as possible to participate in the process
- To contribute towards a best interest decision within the safeguarding process
To provide independent representation of the best interests of the Adult at Risk within the Safeguarding procedure

To do this they will:

- Interview or meet the person if possible
- Liaise with family / important others regarding their views regarding the best interests of the Adult at Risk
- Talk to professionals – paid carers and other people who can give information about the person’s wishes and feelings, beliefs and values
- Access all relevant records from a variety of settings
- Submit a report to the decision maker who will decide who this should be circulated to

There is a statutory requirement to have regard for any representation made by the IMCA whether this is made verbally or within their report.

When does the IMCA’s Involvement End?

Usually once the report has been submitted and a safeguarding plan has been agreed.

Deprivation of Liberty and the IMCA service

There are a number of circumstances in the Deprivation of Liberty Safeguards (DOLS) process where an IMCA may need to be instructed. This is usually done by the representative for the Supervisory Body as part of the administration and processing of the DOLS. These circumstances include:

- An urgent DOLS authorisation or an application for a standard authorisation has been made, and there is no-one involved with
the person, whom it is appropriate to consult, other than people in a professional capacity or paid to be involved

- A person deprived of their liberty is without a relevant person’s representative
- A person deprived of their liberty or their unpaid representative has requested the support of an advocate.
- The supervisory body believes that the person deprived of their liberty and/or their unpaid representative would benefit from the support of an advocate

There is a specific DOLS IMCA referral form to use in these cases. Further information or advice is available from Derbyshire County Council DOLS Team, or the Safeguarding Adults Team in Derby City.
Section 23: Think Family  
Staff Guidance

**Staff Guidance**

Think Family means securing better outcomes for children, adults and families, by co-ordinating the support they receive from different services and focusing on the whole family when investigating concerns and then in the development and implementation of Protection Plans. Think family is fundamental to planning and delivering effective and efficient care and requires all staff to work together in order to improve multi-agency professional practice. In relation to safeguarding concerns, while the referral may identify a particular individual it is important to locate that individual in their wider family and social network. It is also important to consider whether as a result, safeguarding or other referrals need to be considered in relation to others in the wider family and social network.

**Think Family throughout the Safeguarding Process**

Think Family is an approach that needs to inform all aspects of your practice.

When receiving a referral it is important to take details of an Adult at Risk wider family and social network. In carrying out an investigation it is important to talk to the wider family and social network, liaising and seeking advice from other professionals who are working with the wider family and social network. In organising Strategy meetings and Case Conferences it is important to consider what may be gained from inviting the wider family and social network. At the end of the process when developing and implementing Protection plans it is important to look at how they will impact on the wider family and social network.
Throughout this if there are any concerns about a Child’s welfare then it is important to make a referral to the relevant Children and Young People service

**Useful Numbers**

- Call Derbyshire 08456 058 058
- Careline (Derby Social Care ) 01332 786968
- Police Central Referral Unit 0300 122 8719 or 0300 122 4559
Section 24: Outcomes

Outcomes

Safeguarding outcomes have predominantly been described by the process rather than the experience of people who use services.

The IDEA have published standards for Adult Safeguarding which were developed in partnership by:

- The Local Government Group
- Association of Directors of Adult Social Services (ADASS)
- The NHS Confederation
- Social Care Institute for Excellence (SCIE)

The standards set out outcomes for and the experiences of people who use services as follows:

NB The highlighted areas indicate where social workers should pay particular attention in their practice to ensure that outcomes are defined by the individuals concerned.

<table>
<thead>
<tr>
<th>Ideal Service</th>
<th>Probes and Questions</th>
<th>Possible Sources of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outcomes</td>
<td>1.1 Adults at Risk are safeguarded in the</td>
<td>- There is a shared approach to outcomes with the NHS, the police and other partners</td>
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<tr>
<td>Community and in establishments such as care homes and hospitals.</td>
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<td>---------------------------------------------------------------</td>
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<tr>
<td>1.2 The council and its partners’ approach to safeguarding clearly has an outcome based focus</td>
<td></td>
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<tr>
<td>1.3 The council demonstrates improved safeguarding outcomes alongside wider community safety improvements</td>
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<tr>
<td>• Officers and Members work across individual service and agency boundaries and traditional definitions of their roles to improve outcomes</td>
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<tr>
<td>• Outcomes for safeguarding are coherent with outcomes relating to domestic violence, hate crime, anti-social behaviour and community cohesion work.</td>
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<td></td>
</tr>
<tr>
<td>• Outcomes are consistent, regardless of how old people are, whatever their disability or mental health problems, who pays for their care and their Fair Access to Care Services (FACS) eligibility criteria</td>
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<tr>
<td>• The public (including, underrepresented and vulnerable groups), is aware of Adult Safeguarding issues</td>
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<td>• Effective prevention and early intervention is in place</td>
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<tr>
<td>• Prosecutions levels are improving</td>
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<tr>
<td>Strategies, plans and progress reporting and in interviews</td>
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<tr>
<td>Performance reporting includes outcomes measures</td>
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<tr>
<td>Case files. Local Safeguarding Adults Board (LSAB) reports.</td>
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<tr>
<td>Council and LSP reports</td>
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<tr>
<td>LSAB, council and management reports</td>
<td></td>
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<tr>
<td>Council and LSAB publicity and reports</td>
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<table>
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<tr>
<th>2. People’s experiences of safeguarding</th>
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</thead>
<tbody>
<tr>
<td>2.1 The council has achieved high levels of expressed positive experiences from people who have used safeguarding services</td>
</tr>
<tr>
<td>2.2 The council has</td>
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<tr>
<td>• <strong>People experiencing safeguarding services are treated sensitively and with dignity and respect.</strong></td>
</tr>
<tr>
<td>• Advocacy is available for people who are (or may have been) experiencing abuse, including Independent Mental Capacity Advocates</td>
</tr>
<tr>
<td>• There is support available for people who have experienced abuse</td>
</tr>
<tr>
<td>Surveys of people who have used services.</td>
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<tr>
<td>Aggregated reports from reviews</td>
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<tr>
<td>Protocols, strategies, examples of user involvement</td>
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<tr>
<td><strong>fully engaged people who use services in the design of its services</strong></td>
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<td>--------------------------</td>
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<tr>
<td><strong>2.4 Safeguarding is personalised</strong></td>
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</tbody>
</table>

- Vulnerable victims and witnesses are supported through the criminal justice system
- **Outcomes are defined by the individuals concerned**
- **The safeguarding process puts individuals in control, including of whether to involve the police, whether to prosecute, whether family members are involved and in relation to the protection plan**
- Deprivation of liberty safeguards are applied where this is considered and an individual lacks capacity
- There are services available to support carers, to support the improvement of relationships, and for abusers to address their behaviours where appropriate
- Wider family members, friends and neighbours are engaged in safeguarding adults at risk when this is appropriate

| Forms and protocols that use respectful language Focus group with people who use services and carers Policies and procedures File audits Management information Deprivation of Liberty Standards (DoLS) reports |

Outcomes should be clearly recorded on the Part 6 form for Derby City Council Adult Social Care and on the monitoring form for Derbyshire County Council Adult Social Care.