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PREFACE

The Safeguarding Adults Boards in Southend, Essex and Thurrock recognise the vital role that all organisations in Essex play in safeguarding vulnerable adults. As part of their role in working together to ensure that safe and effective systems are in place the Boards have developed these guidelines to set out clearly how concerns about vulnerable adults at risk of abuse will be managed.

The guidelines have been developed within the framework set out in “No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse” (DH 2000). It is however recognised that adult safeguarding has moved on significantly since No Secrets was written including:

- The Law Commission's Review of Adult Social Care legislation
- Implementation of the Mental Capacity Act 2005
- Changes and developments in Domestic Violence legislation
- Developments in how Hate Crime is treated
- Winterbourne View, Ash Court, Mid Staffs and other high profile scandals

The introduction of the Care Bill and associated statutory guidance that are expected to be implemented in 2015 will be particularly important. The safeguarding boards are clear that safeguarding arrangements in Southend, Essex and Thurrock cannot stand still, so this guidance intends to fill the vacuum until legislation is completed.

We are pleased to welcome this document as the result of the co-operation between each of the Safeguarding Boards and their Strategic Partners. We believe it represents a true multi-agency process - comprehensive in its approach to procedures and compliant with both legislation and best practice.

These guidelines will apply in all settings, including those managed by private, voluntary and statutory agencies. Anyone who suspects abuse in any setting should contact Adult Social Care (Southend), Social Care Direct (Essex), Community Solutions Team (Thurrock) or if known the relevant social services team to share their concern.

It is expected that all local adult safeguarding policies will comply with these SET guidelines.

This document has been approved and endorsed by:

Christine Doorly
Chair
Safeguarding Vulnerable Adults Board
Southend on Sea

Simon Hart
Chair
Essex Safeguarding Adults Board

Les Billingham
Chair
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Thanks are due to the SET Working Group who oversaw the guideline’s development.

This steering group will continue to keep the document under review to take account of changes in legislation, government policy, research findings, and professional experience. For further details regarding this group or these guidelines, please contact: Michala Jury (michala.jury@essex.gov.uk).
When should the SET Adult Safeguarding Guidelines be used?

The SET Adult Safeguarding guidelines are designed to be used in circumstances where a vulnerable adult is experiencing abuse. This could be where they are not being treated with dignity and respect or where their human rights are not being protected. In these circumstances it will be important that agencies work collaboratively to safeguard and protect people using services.

It is important to recognise that there are occasions where customers and their families may be provided with support and help to manage risks around their safety that do not involve abuse. In these circumstances it may be more appropriate to follow alternative paths, for example, care management, complaints, serious incident processes.

If unsure whether a safeguarding concern should be raised you should contact your organisations adult safeguarding lead who will be able to discuss with you further. Alternatively you can discuss with the social services department for your area.

Links for flowchart:
2.2.14
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1. STRATEGIC MANAGEMENT

1.1 THE ROLE OF AREA SAFEGUARDING BOARDS

Local authorities are required to ensure that there is an Adult Safeguarding Board covering their area, which brings together representatives of each of the main agencies, and professionals responsible for helping to protect vulnerable adults from abuse and neglect.

Roles and Responsibilities

- To develop and agree local policies and procedures for inter-agency work to protect vulnerable adults
- To audit and evaluate how well local services work together to protect vulnerable adults
- To put in place objectives and performance indicators for adult safeguarding
- To encourage and help develop effective working relationships between different services and professional groups, based upon trust and mutual understanding
- To ensure agreement across agencies about operational definitions and thresholds for intervention
- To improve local ways of working in light of knowledge gained through national and local experience and research, and to make sure lessons are acted upon
- To help improve the quality of vulnerable adult safeguarding work through inter-agency training and development
- To raise awareness within the wider community for the need to safeguard vulnerable adults and explain how the wider community can contribute to these objectives

(‘No Secrets’ – Department of Health 2000)

In addition to the roles and responsibilities set out in No Secrets, in some instances where it is considered that there are opportunities for learning and improvement in practice, a ‘Serious Case Review’ may be convened. These will be based on the criteria set down by each Local Safeguarding Board.
2. GUIDELINES

2.1 VALUES AND PRINCIPLES

2.1.1 Everyone engaged in the safeguarding of vulnerable adults will be expected to adhere to working practices in accordance with maintaining, choice, rights, fulfilment, independence, privacy, and dignity for the individuals concerned.

2.1.2 The Southend Essex and Thurrock (SET) Safeguarding Vulnerable Adults Guidelines are based on the values and principles below:

- It is the responsibility of everyone to recognise suspected or actual abuse and to take appropriate action in line with the procedures in this document. **IGNORING ABUSE IS NOT AN OPTION!**

- All individuals, regardless of Age, Disability, Gender Reassignment, Marriage & Civil Partnership, Pregnancy & Maternity, Race, Religion & Belief, Sex or Sexual Orientation should have the greatest possible control over their lives

- People should be able to live as independently as possible and to make informed decisions about their own lifestyles, including the opportunity to take risks if they choose to do so, without fear of harm or abuse from others. It should be acknowledged that these decisions may be viewed as unsafe or unwise and must be heeded if a person has the capacity to make the specific decision. ‘A person is not to be treated as unable to make a decision merely because he makes an unwise decision’ (Mental Capacity Act 2005 (MCA))

- People have a right to express their wishes and priorities and to be personally involved when plans are made for their care. Every effort should be made to enable people to express their wishes in a way that is appropriate for them

- In any intervention to reduce risk or respond to immediate danger, care should be taken to ensure the least possible disruption of people’s lives. Every effort will be made to ensure that the vulnerable adult(s) who have allegedly been abused, or witnessed such abuse, or their nominated representative, will be involved as much as practically possible with the procedures in this document and be supported throughout the process

- In May 2011 the Department of Health issued a statement on Safeguarding Adults which sets out six safeguarding principles which should underpin all safeguarding work.
  - **Empowerment** - Presumption of person led decisions and informed consent.
  - **Protection** - Support and representation for those in greatest need.
  - **Prevention** - It is better to take action before harm occurs.
GUIDELINES

- **Proportionality** - Proportional and least intrusive response appropriate to the risk presented.
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in delivering safeguarding.

These principles should underpin all safeguarding work. For instance a carpet in a care home that has a hole in it is not a safeguarding issue but one about the maintenance of the home, a carer found asleep on duty is not a safeguarding issue but a management issue. However, in some cases, if the carpet remains in a state of disrepair and accidents occur then this could be a safeguards issue. If a carer is asleep on duty and resident is taken ill and left unattended then this could be a safeguards matter.

2.1.3 If a vulnerable adult has been deemed to lack capacity under the principles of the Mental Capacity Act 2005, the person making the decision on their behalf can:

- Bring a complaint of alleged abuse on behalf of the adult without capacity
- Be informed as appropriate of the progress of the enquiry
- Make a complaint under the statutory complaints procedures

2.1.4 Staff have the right to be given support and protection to help them in exercising their responsibilities in respect of abuse, without fear, in accordance with the employer’s Whistleblowing Policy (see Whistleblowing Section in ‘Additional Guidance’)

- Where a staff member’s safeguarding concerns appear not to be taken seriously or there would be a delay in reporting, it is appropriate to take them to a more senior person and in exceptional circumstances outside of their agency to an independent body e.g. adult social services or a regulatory body. Staff taking this action will be supported by their organisation regardless of the outcome, providing the allegation has been made in good faith
- ‘If it is determined that a person lacks capacity then any decision taken on their behalf must be in their best interest (MCA 2005)’
- To provide a safe environment in which to work and receive services, without fear of reprisal and in accordance with the organisation’s Whistleblowing Policy
- To encourage an atmosphere of openness and effective communication so that staff can approach their line manager, a more senior person or social services with any suspicions regarding abuse
- To treat information about suspected abuse in a professional and objective manner
- To keep all relevant persons informed of action taken and outcomes
To ensure that all their own staff members have adequate and appropriate training for their roles and responsibilities within adult safeguarding. For further details on the SET Training strategy http://dnn.essex.gov.uk/esab/Guidelines,FormsDocuments/GuidelinesandPolicy.aspx

2.2 DEFINITIONS

2.2.1 Abuse

Abuse is a violation of an individual’s human and civil rights by any other person or persons. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. (No Secrets DH 2000)

2.2.2 Adult

Any person aged 18 years or over.

Alert: An alert is defined as a feeling of anxiety or worry that a vulnerable adult may have been, is, or might be, a victim of abuse. This would be the first contact between the source of the referral and the local authority safeguarding team/service about the alleged abuse.

Referral: Cases which do not meet the SET Guidelines safeguarding threshold and are therefore not fully investigated should not be counted as a referral and are therefore considered ‘alerts’.

2.2.3 Allegation

An allegation is an assertion by the vulnerable adult, or other person(s) that the vulnerable adult is or has been a victim of abuse, and can include a statement regarding the alleged perpetrator.

2.2.4 Anti-Social Behaviour

Anti-social behaviour is any aggressive, intimidating or destructive activity that damages or destroys another person’s quality of life.

2.2.5 Case Co-ordinator

‘Someone who co-ordinates communication between two or more people or groups’.

It is important to state that the co-ordinator is not to be seen as having assumed case management responsibility, as this will remain the responsibility of the officially allocated worker.
Within the safeguarding adult process, the role of co-ordinator is primarily a central point of contact and liaison for all parties and for the collating of information and reports which will form part of any safeguarding process.

Each safeguarding situation will vary and the professionals will retain their own responsibilities within the process, (i.e. health, social care) and may have related tasks identified during the safeguarding process. The success of any safeguarding plan will be dependent on all parties effectively working together.

It is recommended that the case co-ordinator should be someone who has access to administrative skills or support.

2.2.6 Case Management

The resolution of the risks identified by use of a personal support plan implemented and monitored by a care manager or social worker.

2.2.8 Disclosure

A disclosure occurs when the vulnerable adult says or implies that they are being, have been, or are at risk of being abused. Disclosure may be direct, or may take the form of odd hints or veiled comments.

2.2.9 Hate Crime

Hate crime is a term used to describe an offence committed against a person because of hate or prejudice. It affects such a range of people it is difficult to define but we describe it as, any incident, which may be a criminal offence, motivated by prejudice or hatred towards a particular social group because of their:

- Race, Colour, Ethnic origin and Nationality
- Religion and Faith
- Gender or Gender Identity
- Sexual Orientation
- Disability and Learning Difficulties
- Mental Health

Hate crimes can take many forms which can include:

- Physical attacks – physical assault, damage to property, offensive graffiti, neighbour disputes and arson
- Threat of attack or bullying – offensive letters, abusive telephone calls, malicious complaints
- Verbal insults or abusive gestures

2.2.10 Incident

An occurrence or event that gives rise to a concern or allegation.
2.2.11 Indicators

An indicator is a sign, symptom or behaviour that should alert the person noting / observing it, that the vulnerable adult may have been, is or might be a victim of abuse. *(See section 2.3)*

2.2.12 Self-Neglect

Self-neglect may or may not be a safeguarding issue, however agencies must assess concerns raised under their statutory duties; having consideration for an individual’s right to choose their lifestyle, balanced with their mental health or capacity to understand the consequences of their actions.

Once identified as a situation that cannot be managed through regular case management, high risk or self-neglect situations will be managed through the safeguarding process following receipt of SET SAF1 outlining the risks involved.

The flow charts *(Appendix 5)* outline the process to be followed.

2.2.13 Significant harm

Ill-treatment, (including sexual abuse and forms of ill-treatment that are not physical); the impairment of, or an avoidable deterioration is physical or mental health and the impairment of physical, emotional, social or behavioural development.

(“Who Decides” Lord Chancellor’s Department 1997)

There is no absolute criteria to refer to when judging what constitutes significant harm. Consideration should be given to the severity of ill-treatment, which may include the degree and extent of the harm, the duration and frequency of abuse and neglect, the extent of the premeditation the susceptibility of the victim to be affected by the ill treatment, and the pressure or degree of threat or coercion. It is the adverse impact of the event on the individual(s) that has to be considered. Sometimes, a single traumatic event may constitute significant harm (e.g. assault). However, more often significant harm is a compilation of significant events that has an impact on the individual(s).

2.2.14 Vulnerability

A vulnerable adult refers to any person aged 18 years or over, who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation which may be occasioned by actions or inactions of other people.

(“No Secrets” DH 2000)
2.2.15 Exploitation

Exploitation can be seen as taking advantage of a vulnerable person in an unjust or unethical way for one’s own gain, to the detriment of that person. For example, using someone’s vulnerability in order to attain personal benefit at the expense of the vulnerable person(s).

2.2.16 Risk

Risk is not, in itself, a safeguarding issue. Risks are hazards that could have a negative impact on an individual. Social Care has a strong focus on enabling adults to live independently by giving them a choice of services, such as individual budgets which enables them to take control of their life. This will inevitably involve a degree of risk, and whilst not all risk can be eliminated, it can be managed.

2.2.17 Undue Influence

Undue influence occurs when –

- The unduly influenced person has the mental capacity to make the decision in question but their will has been overborne not just by influence but by the undue influence of somebody else.
- The person is influenced to enter into a transaction concerning a gift, or a will, in such a way that it is not of their own free will or that the person lacked capacity at the relevant time.
- There are two types of undue influence –
  
  (i) “express”, when there is evidence of coercion or undue pressure
  (ii) “presumed” when there is no such evidence but it has occurred when the relationship is of an unequal nature and one person is taking unfair advantage of another

What is the role of the practitioner and the safeguarding interventions that can be offered in incidents of undue influence:

- If it is before the transaction occurs and it is appropriate, the practitioner can suggest that independent advice is required e.g. via a solicitor or an accountant.
- If a criminal offence seems to have been committed then police involvement should be considered and sought.
- The basis for undue influence is the establishment of dishonesty and this can relate to a living or dead person.

2.2.18 Serious Incident (SI)

All NHS organisations have a mechanism for reporting all clinical, non- and near miss incidences; all incidences deem very high risk and/or serious, go
onto be deemed a Serious Incident (SI) and under all NHS organisations do this under a local SI policy.

Locally in the NHS, incident reporting is undertaken via an electronic system. This feeds into the framework for the management of those incidences deemed Serious Incident. This is in accordance with best practice and in line with the expectations of Clinical Commissioning Groups (CCG) and in adherence to the National Patient Safety Agency (NPSA), The NHS Litigation Authority (NHSLA), the Care Quality Commission (CQC) and Monitor. This process will occur for all incidences; some of which will also be deemed a Safeguarding Adults Incident reportable under these guidelines to the Local Authority for investigation, however time frames for an SI investigation that are serious enough to require application of the full process are longer at 45 days.
2.3 TYPES OF ABUSE & POSSIBLE INDICATORS

ABUSE

2.3.1 Abuse is a violation of an individual’s human and civil rights by any other person or persons. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. (No Secrets, Department of Health 2000)

2.3.2 Abuse can take place in any setting - these guidelines are applicable to all settings; individual’s private home, care home, hospital, day service, public transport, park, police station, college. This list is endless.

It is therefore, also important to recognise that abuse can consist of a single or repeated acts; that it can be intentional or unintentional or result from a lack of knowledge. Abuse can be an act of neglect or an omission or a failure to act. Abuse can cause temporary harm or exist over a period of time and can occur in any relationship. Abuse can be perpetrated by anyone, individually or as part of a group or organisation. Importantly, abuse can often constitute a crime.

Abuse is NOT an accident and nor is an accident abuse. For example, if someone who is usually able to drink independently is handed a cup of tea, which they then spill resulting in red marks to the top of their legs, then this would be an accident. Whereas, if a person who is known not to be able to drink independently with an adapted cup is handed a cup of tea in a standard cup and is left to try to drink it independently but subsequently spills it and sustains a scald then this may constitute negligence

TYPES OF ABUSE

2.3.3 The following pages describe some of the types of abuse and possible indicators which might be encountered, and it may be that abuse encountered does not fit neatly into any one of these categories – it should be noted this list is by no means exhaustive.

* Physical Abuse
* Emotional Abuse
* Sexual Abuse
* Neglect, Wilful Neglect and Acts of Omission
* Discriminatory Abuse
* Financial/material Abuse
* Institutional Abuse
PHYSICAL ABUSE

2.3.4 The non-accidental infliction of physical force that results (or could result) in bodily injury, pain or impairment. Examples include:

- An inflicted physical injury, which is not satisfactorily explained
- An injury where there is knowledge or suspicion that it was inflicted intentionally or through lack of care
- Assaults on the body including hitting, slapping, pushing, kicking resulting in injuries such as burns, abrasions, fractures, dislocation, welts, wounds or marks of physical restraint
- Misuse of medication or medical process e.g. catheterisation
- Inappropriate restraint or inappropriate actions or inactions

Possible indicators of physical abuse are:

- Multiple bruising that is inconsistent with the explanation given
- Cowering and flinching
- Bruises or marks resulting from a slap or kick
- Abrasions, especially to neck, wrists and/or ankles
- Unexplained burns
- Scalds, especially with a well-defined edge from immersion in water
- Hair loss in one area, scalp sore to touch
- Frequent minor accidents without seeking medical help
- Unusually sleepy or docile
- Unexplained fractures
- Frequent “hopping” from one GP to another or from one care agency to another
- Untypical self-harm, emotional distress, low self esteem

EMOTIONAL ABUSE

2.3.5 Acts or behaviour which impinges on the emotional health of, or which causes distress or anguish to individuals. This may also be present in other forms of abuse. Examples include:

- Threats of harm or abandonment
- Humiliation, shaming or ridicule
- Harassment, bullying, intimidation
- Control or coercion
- Deprivation of choice or privacy
- Deliberate social isolation
- Infantilisation – treating an adult like a child

Possible indicators of emotional abuse are:

- Disturbed sleep or tendency to withdraw to a room or to bed
- Loss of appetite or over eating especially at inappropriate times
- Anxiety, confusion or general resignation
- Extreme submissiveness or dependency in contrast to known capacity
- Sharp changes in behaviour in the presence of certain person(s)
GUIDELINES

- Excessive or inappropriate craving for attention
- Self-abusive behaviour – self-mutilation, head banging, hand biting
- Loss of weight without apparent loss of appetite
- Loss of confidence

SEXUAL ABUSE

2.2.6 Direct or indirect involvement in sexual activity without consent. This could also be the inability to consent, pressured or induced to consent or take part. For more details regarding Safeguarding Adults and the law please see http://mandelstam.co.uk/MendBooks1.html

Examples include:

- Rape
- Indecent assault
- Indecent exposure
- Exposure to inappropriate sexual behaviour or images/material

Possible indicators of sexual abuse are:

- Unexplained and uncharacteristic changes in behaviour
- New tendency to withdraw and spend time in isolation
- Recent development of openly sexual behaviour/language
- Deliberate self-harm
- Incontinence/bedwetting
- Irregular or disturbed sleep patterns
- Difficulty/discomfort in walking
- Unexplained soreness around the genital area
- Repeated urinary tract infections
- Bruising or bleeding in the genital or rectal area
- Excessive washing
- Unexplained “love bites”
- Stained or torn underclothing especially with blood or semen
- Sexually transmitted disease
- Pregnancy

NEGLECT, WILFUL NEGLECT AND ACTS OF OMISSION

2.3.7 Ignoring or withholding physical or medical care needs which result in a situation or environment detrimental to individual(s). Ill-treatment and wilful neglect of a person who lacks capacity are now criminal offences under the Mental Capacity Act. Examples include:

- Failure of a person who has responsibility, charge, care or custody of a vulnerable person, to provide access to appropriate health, social care or educational services (unintentional or deliberate)
- Withholding necessities of life, including nutrition, medication, heating, shelter (unintentional or deliberate)
- The failure to intervene in behaviour which is dangerous to the vulnerable adult or to others
Repeated incidences of poor care e.g. poor moving and handling – see also institutional abuse

Possible indicators of neglect are:
- Poor hygiene and cleanliness of a person who has assistance with their personal care
- Unkempt or unsuitable clothing for the weather conditions/environment
- Untreated illness or condition
- Dehydration, weight loss, malnutrition
- Repeated infections
- Repeated/unexplained falls or trips
- Unexplained or untreated pressure ulcers or other sores
- Inadequate heating or lighting available
- Incontinence issues not addressed - e.g. odour on clothes and/or furnishings
- Clear failure to ensure the taking of medication appropriately
- Inconsistent or reluctant contact with health or social care agencies
- Withholding of appropriate devices such as hearing aids, glasses etc.
- Appropriately treated illness or condition

Practitioners must respect the rights of the service users whilst seeking to ensure that their behaviour does not harm themselves or others. This means that there is an inherent right for the service user to take risks and a responsibility for the practitioner to help them identify and manage potential and actual risk to themselves and others. However, ignoring the risk or making the risk worse (intentionally or unintentionally) and placing an individual at harm is a safeguarding matter.

Risk management is a continuing process not an event. Risk assessments should lead to a risk management plan that is regularly reviewed, and updated, with the service user.

DISCRIMINATORY ABUSE

2.3.8 Discriminatory abuse exists when values, beliefs or culture result in a misuse of power that denies mainstream opportunities to some groups or individuals.

2.3.9 It includes discrimination on the basis of race, gender, age, sexuality, disability or religion, examples of which are:

- Age
- Disability
- Gender Reassignment
- Marriage & Civil Partnership
- Pregnancy & Maternity
- Race
- Religion & Belief
- Sexual Orientation

Possible signs of discriminatory abuse are:
GUIDELINES

- The vulnerable person is subjected to racist, sexist/gender or homophobic abuse
- The vulnerable person is subject to abuse relating to their age, illness or disability
- Not meeting cultural or religious needs
- Imposing unwanted political, cultural, religious beliefs
- Acts or comments motivated to harm and damage, including incitement of others to commit abuse based on difference
- Lack of effective communication provision e.g. interpreters, BSL etc.

FINANCIAL/MATERIAL ABUSE

2.3.10 Unauthorised, fraudulent obtaining and improper use of funds, property or any resources of a vulnerable person. Examples include:

- The misuse or misappropriation of property, possessions or benefits
- Theft, fraud, exploitation
- Pressure in connection with wills, property or inheritance or financial transactions
- Extortion of money, property and possessions by threat, coercion or fraudulent means
- Refusal to let the vulnerable person have access to their own money, property or possessions

Possible signs of financial/material abuse are:

- Unexplained or sudden inability to pay bills
- Unexplained or sudden withdrawal of money from accounts
- Personal possessions of value go missing without explanation
- Contrast between known income and actual living conditions
- Someone responsible for paying bills, buying food etc, is not doing so
- Unusual interest by a relative, friend or neighbour etc, in financial assets especially if little real concern is shown in other matters
- Next of kin insists on informal arrangements re: financial affairs despite being advised about powers of attorney arrangements Where services are refused under pressure from potential beneficiaries
- Unusual purchases unrelated to the known interests of the vulnerable people

INSTITUTIONAL ABUSE

2.3.11 Institutional abuse occurs where the culture of the organisation (such as a care home) places emphasis on the running of the establishment and the needs of the staff above the needs and care of the vulnerable person. Abuse by an organisation imposing rigid and insensitive routines; poor practices embedded in systems, unskilled, intrusive or invasive interventions; or an environment allowing inadequate privacy or physical comfort.

Possible indicators of institutional abuse are:

- Lack of or inappropriate care plans – not regularly reviewed
- Contact with the outside world not encouraged
GUIDELINES

- Few visitors or notification required before visiting
- Visiting restricted, not accounting for individuals preferences or allowing privacy on visits
- Little opportunity for outside activities
- Routines of “care” engineered for the convenience of staff
- No choice or flexibility e.g. getting up or going to bed
- Lack of choice or consultation about meals or opportunities for snacks and drinks
- Lack of consultation, involvement, preparation, discussion when medical or personal care tasks carried out
- Lack of privacy e.g. not knocking before staff enter bedrooms
- Lack of privacy when carrying out personal care tasks
- Unusually subdued behaviour
- Residents keep out of the way of staff
- Care of personal clothing lacking, dressed in other peoples clothes, given others spectacles, teeth, or hearing aids
- Strong smell of urine – bed linen or clothes not changed appropriately
- Chairs/tables positioned to restrict movement
- Inappropriate use of medicines or nursing procedures to make clients easier to manage rather than for bona fide health needs
- Not allowing views or opinions to be expressed
- Loss of rights as a citizen e.g. denying opportunity to vote
- Poor moving and handling practice

Specific guidance for managing institutional safeguarding cases is available in some council areas (for example Essex), you should check with your local safeguarding lead to see if such guidance is available in your area.

2.4 CAPACITY, CONSENT & DECISION MAKING

Section 2 of The Mental Capacity Act 2005 states:

(1) ‘For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.’

(2) It does not matter whether the impairment or disturbance is permanent or temporary.

(3) A lack of capacity cannot be established merely by reference to –

   (a) a person’s age or appearance, or
   (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

Mental Capacity Act 2005 - Code of Practice states:

“Mental Capacity is the ability to make a decision”
GUIDELINES

- This includes the ability to make a decision what affects daily life – such as when to get up, what to wear or whether to go to the doctor when feeling ill – as well as more serious or significant decisions.
- It also refers to a person’s ability to make a decision that may have legal consequences – for themselves or others. Examples include agreeing to have medical treatment, buying goods or making a will.

The starting point must always be to assume that a person has the capacity to make a specific decision. Some people may need help to be able to make or communicate a decision but this does not necessarily mean that they lack capacity to do so. What matters is their ability to carry out the processes involved in making the decision – and not the outcome.”

2.4.1 The expressed wishes of vulnerable adults should, where possible, be paramount in the decision making process. However, there remains a fundamental duty to balance the person’s right to autonomy with their, or the public need for protection.

2.4.2 The principles of the Mental Capacity Act should be followed at all times where lack of capacity of an individual is assessed.

2.4.3 An Independent Mental Capacity Advocate (IMCA) should be appointed in line with the guidance in Section 6.6 of this policy, (Chapter 10 of the Code of Practice MCA - http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act) in order to support people who lack capacity through the safeguarding process.

2.4.4 Please refer to MCA code of practice and also to local procedures.
3. AGENCY ROLES & RESPONSIBILITIES FOR SAFEGUARDING INVESTIGATIONS

Department of Health issued statutory guidance in 2006 (Guidance on the Statutory Chief Officer Post of the Director of Adult Social Services, May 2006) sets out that Directors of Adult Social Services have responsibility and authority for ensuring that their local authority maintains a clear organisational and operational focus on safeguarding vulnerable adults.

In addition to the responsibility to report all alleged concerns in the first instance to the relevant social services department, further agency roles and responsibilities are set out below.

<table>
<thead>
<tr>
<th>Clinical Commissioning Groups</th>
<th>Role</th>
<th>Responsibility/Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Ensuring health care providers have appropriate systems and processes in place to safeguard vulnerable adults</td>
<td>• Ensure that there is appropriate health service involvement into investigations where there are concerns about the health care provision</td>
<td>• Monitor the performance of commissioned healthcare providers and take appropriate action.</td>
</tr>
<tr>
<td>▪ Ensure that there is appropriate health service involvement into investigations where there are concerns about the health care provision</td>
<td></td>
<td></td>
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<tr>
<td>▪ Ensuring scrutiny of the complaints process (following a complaint/concern that may be raised by patients) against agencies if the Clinical Commissioning Group is lead investigator.</td>
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<tr>
<td>▪ Assist with the investigation and action as appropriate where there is a health related concern and no other health services are involved.</td>
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<tr>
<td>▪ Assist with safeguarding investigations where concerns are raised around care for someone who has their care funded by the health service.</td>
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<tr>
<td>▪ Assist with the safeguarding investigation where the concerns raised appear to amount to institutional abuse.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Authority Commissioned services</th>
<th>Role</th>
<th>Responsibility/Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Ensuring social care providers have appropriate systems and processes in place to safeguard vulnerable adults</td>
<td>• Co-ordinating all instances of alleged abuse that happens within their local area</td>
<td>• Commission and monitor social care providers and take appropriate action.</td>
</tr>
<tr>
<td>▪ Co-ordinating all instances of alleged abuse that happens within their local area</td>
<td>• Work in partnership with other agencies to ensure the safety and protection of vulnerable adults living in the community</td>
<td>• Undertake action in accordance with the conduct and capability policies and procedures of the agency.</td>
</tr>
<tr>
<td>▪ Work in partnership with other agencies to ensure the safety and protection of vulnerable adults living in the community</td>
<td>• Follow the organisation’s complaints process to investigate complaints made against the organisation/department.</td>
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<tr>
<td>▪ Work with partners such as police, local councils, health agencies, other regulators and government departments.</td>
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</table>

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<thead>
<tr>
<th>Health Care Providers including:</th>
<th>Role</th>
<th>Responsibility/Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Ensuring that there are appropriate systems and</td>
<td>• Undertake action in accordance with the conduct and capability policies and procedures of the agency.</td>
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<tr>
<td>AGENCY ROLES &amp; RESPONSIBILITIES</td>
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<td>---------------------------------</td>
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<td></td>
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<tr>
<td><strong>Agencies Involved:</strong></td>
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<tr>
<td>• Acute Trusts/Hospitals</td>
<td></td>
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<tr>
<td>• Community Health Services</td>
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<td></td>
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<tr>
<td>• Mental Health (both Inpatient and Community)</td>
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<td></td>
</tr>
<tr>
<td>• Learning Disability (both Inpatient and Community)</td>
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<td></td>
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<tr>
<td><strong>Processes Involved:</strong></td>
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<tr>
<td>• Ensuring that the organisation participates in investigations where the organisation is involved in the provision of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assisting the local authority with any safeguarding investigations where the service is involved with the provision of care by providing a report of their views/ interventions/ findings.</td>
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<tr>
<td>• Follow the organisation’s complaints process to investigate complaints made against the organisation/department.</td>
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<tr>
<td>• Submit reports to Clinical Commissioning Group lead as agreed.</td>
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</table>

**Mental Health Partnership Trusts**

- Investigating safeguarding referrals/alerts for adult service users with serious and enduring mental health problems
- To work in partnership with the Local Authority safeguarding teams in providing information for safeguarding investigations
- Investigating alleged or suspected breaches of organisational/ departmental standards by staff members
- Investigating complaints made against the organisation/ department made by:
  - Patients for whom the organisation/ department has responsibility
  - Members of the public in accordance with the organisations/ department’s policies and procedures
- To provide information in accordance with

**Undertake Action in accordance with the disciplinary policies and procedures of the organisation/department.**
confidentiality protocols in relation to a vulnerable adult:
- Sensory functions
- Mobility
- Physical condition
- Mental condition
- Social environment
- Use of medicines

<table>
<thead>
<tr>
<th>AGENCY ROLES &amp; RESPONSIBILITIES</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>The Police &amp; other law enforcement agencies</strong></td>
<td><strong>The Police &amp; other law enforcement agencies</strong></td>
</tr>
<tr>
<td>Investigate alleged or suspected criminal offences against vulnerable adult(s).</td>
<td>Investigate alleged or suspected criminal offences against a vulnerable adult.</td>
</tr>
<tr>
<td>To support vulnerable adults of alleged or suspected offences, and enable them to access support services e.g. victim support, social care</td>
<td></td>
</tr>
</tbody>
</table>

| **Third, Public & Private Sector agencies including:** | **Third, Public & Private Sector agencies including:** |
| Providers of health & social care | Providers of health & social care |
| Providers of sheltered & supported housing | Providers of sheltered & supported housing |
| Providers of other services for vulnerable adults | Providers of other services for vulnerable adults |
| Investigating alleged or suspected breaches of organisational/ departmental standards by staff members. | Undertake action in accordance with the disciplinary policies and procedures of the agency. |
| Investigating complaints against the organisation/ department made by: |  |
| - Clients for whom the agency has responsibility |  |
| - Members of the public in accordance with the policies and procedures of the agency |  |
| - Assisting the local authority with any safeguarding investigations where the service is involved with the provision of care or support by providing a report of their views/intentions/ findings |  |

| **Advocacy** | **Advocacy** |
| Working with the | Undertake visits to clients and their significant |
### AGENCY ROLES & RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Ensure informed choices can be made by providing timely and accurate information</th>
<th>vulnerable adult and their families &amp; friends to achieve the best outcome for them</th>
<th>To work within the advocacy charter.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To work in partnership with all other agencies to achieve that outcomes</td>
<td>• To act as a bridge between statutory agencies and clients</td>
<td></td>
</tr>
<tr>
<td>Care Quality Commission</td>
<td>Care Quality Commission</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>• Require compliance with the Care Standards Act 2000 and subsequent amendments to the Act. Require compliance with the Health and Social Care Act 2008, associated regulations and Essential Standards of Quality and Safety.</td>
<td>• Use information received (particularly when concerns are raised about abuse, harm or neglect) to monitor and report care services’ compliance.</td>
<td>• Use information received (particularly when concerns are raised about abuse, harm or neglect) to monitor and report care services’ compliance.</td>
</tr>
<tr>
<td>Local Authority Social Services Departments</td>
<td>Local Authority Social Services Departments</td>
<td>Local Authority Social Services Departments</td>
</tr>
<tr>
<td>• To establish the level of vulnerability of the adult who is the subject of the concern</td>
<td>• Co-ordinating all instances of alleged abuse that happens within their local area and collate statistics and report them back to the Board</td>
<td>• Refer concerns to local councils and/or the police for further investigation.</td>
</tr>
<tr>
<td></td>
<td>• To work in partnership with other agencies to promote and ensure the safety and protection of vulnerable adults living in the community</td>
<td>• Work with partners such as police, local councils, health agencies, other regulators and government departments.</td>
</tr>
<tr>
<td></td>
<td>• Investigating alleged or suspected breaches of organisational/departmental standards by social care staff</td>
<td>• Use unique perspective across health and social care to report findings about safeguarding issues.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Undertake action in accordance with either the disciplinary policies and procedures or the complaints policy of the organisation.</td>
<td></td>
</tr>
</tbody>
</table>
**AGENCY ROLES & RESPONSIBILITIES**

<table>
<thead>
<tr>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigating complaints made against the organisation/department made by:</td>
</tr>
<tr>
<td>Vulnerable adults for whom the organisation/department have responsibility</td>
</tr>
<tr>
<td>Members of the public in accordance with policies of the organisation/department &amp; other organisations</td>
</tr>
</tbody>
</table>

**Disclosure and Barring Service**

- Organisations employing staff have a DUTY to refer to the DBS under certain circumstances. Local authorities have a power to refer to the DBS in certain circumstances. DBS considers information from providers/local authorities/other sources regarding the suitability of people to work with vulnerable adults/children. The DBS maintains the list of individuals who have been barred from working with adults/children and discloses this information via the CRB process which the DBS hosts.

For more information on the DBS: [https://www.gov.uk/government/organisations/disclosure-and-barring-service/about](https://www.gov.uk/government/organisations/disclosure-and-barring-service/about)

**Office of the Public Guardian**

- The Office of the Public Guardian has a duty to investigate allegations of misappropriate use of LPAs/Deputyships. The OPG has a Safeguarding Adults Investigation Protocol

[http://www.justice.gov.uk/about/ogp](http://www.justice.gov.uk/about/ogp)
4. INFORMATION SHARING & CONFIDENTIALITY

An Information Sharing Protocol for Safeguarding adults has been signed and can be found on http://www.essexpartnershipportal.org/pages/index.php?page=essex-trust-charter

When sending any SET SAF form by email or any other relevant documentation connected to the forms, this must be done adhering to national guidance and legislation.

IF AN INDIVIDUAL WORKER HAS ANY DOUBT AS TO THE LEGALITY OF SHARING INFORMATION THEY MUST APPROACH THEIR LEGAL ADVISORS FOR ASSISTANCE AND ADVICE.

4.1 Why is it necessary to share information and with whom?

4.1.1 ‘No Secrets’ [DH 2000] states that the government expects organisations to share information about individuals who may be at risk from abuse. This is also stressed by Safeguarding Adults [ADSS 2005]: The framework for good practice. It is important to identify an abusive situation as early as possible so that the individual can be protected. Withholding information may lead to abuse not being dealt with in a timely manner. Confidentiality must never be confused with secrecy.

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

4.2 Seven golden rules for information sharing

The following is taken from information sharing guidance: HM Gov 2008: full guidance available here: advice for practitioners in Children and Adults services

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.
2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.
4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of
consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

4.3 Consent - Whose consent should be sought?

4.3.1 It is good practice to seek consent of an adult where possible. All people aged 16 and over are presumed, in law, to have the capacity to give or withhold their consent to sharing of confidential information, unless there is evidence to the contrary.

4.3.2 The Mental Capacity Act 2005 Code of Practice defines the term ‘a person who lacks capacity’ as a person who lacks capacity to make a particular decision or take a particular action for themselves, at the time the decision or action needs to be taken.

4.3.3 A person who is suffering from a mental disorder or impairment does not necessarily lack the capacity to give or withhold their consent for information sharing. Equally, a person who would otherwise be competent may be temporarily incapable of giving valid consent due to factors such as extreme fatigue, drunkenness, shock, fear, severe pain or sedation. The fact that an individual has made a decision that appears to others to be irrational or unjustified should not be taken on its own as conclusive evidence that the individual lacks the mental capacity to make that decision. If, however, the decision is clearly contrary to previously expressed wishes, or is based on a misperception of reality, this may be indicative of a lack of capacity and further investigation will be required.

4.3.4 All decisions taken on behalf of a person who lacks capacity must be taken in their best interests. A judgement about best interests is not an attempt to determine what the person would have wanted. It is as objective a test as possible of what would be in the person’s actual best interests, taking into account all relevant factors. Factors to be addressed include:

• the person’s own wishes (where these can be ascertained); and

• the views of those close to the person, especially close relatives, partners, carers, welfare attorneys, court-appointed deputies or guardians.

4.3.5 If you consider that an adult may not have the capacity to give ‘informed consent’ for information sharing, you must follow the Mental Capacity Act 2005 Code of Practice. If you judge that an individual does not have the
capacity to make decisions, their views should still be sought as far as possible.

4.4 Relevant law

- Data Protection Act 1998 – enables individuals to access information about themselves and places legal obligations on organisations with regard to the keeping and processing of personal information

- Human Rights Act 1998 (incorporating the European Convention on Human Rights into domestic law) - protects a person's right to family and private life though this is a qualified right

- Freedom of Information Act 2000 – allows for people to access information held by organisations which is not personal information. There are exemptions to providing information. Management and legal advice must be sought before a disclosure is made under the Freedom of Information Act

- Crime and Disorder Act 1998 – enables the sharing of information with relevant authorities in the investigation and prevention of crime

4.5 Common Law

- There is a common law “Duty of Confidence”, where a person has a right to expect information given in confidence to be kept confidential by the person receiving the information i.e. doctor and patient, solicitor and client

4.5.1 The “Duty of Confidence” is not absolute, disclosure can be justified:
   i) If when looked at the information is not of a confidential nature and can be accessed elsewhere
   ii) If it is in the public interest to disclose the information
   iii) If a Court orders the disclosure
   iv) If there is another legal obligation to disclose

4.5.2 When deciding on disclosing information without consent of the person the disclosure would have to be proportionate to the need to protect the vulnerable adult.

4.5.3 Public interest test – Is there sufficient public interest to share the information?

4.5.4 Even where you do not have consent to share confidential information, you may lawfully share it if this can be justified in the public interest. Seeking consent should be the first option. However, where consent cannot be obtained or it is refused, or where seeking it is inappropriate or unsafe, the question of whether there is a sufficient public interest must be judged by the practitioner on the facts of each case. Therefore, where you have a concern about a person, you should not regard refusal of consent as necessarily precluding the sharing of confidential information.
4.5.5 A public interest can arise in a wide range of circumstances, for example, to protect children from significant harm, protect adults from serious harm, and promote the welfare of children to prevent crime and disorder. There are also public interests, which in some circumstances may weigh against sharing, including the public interest in maintaining public confidence in the confidentiality of certain services.

4.5.6 The key factors in deciding whether or not to share confidential information are necessity and proportionality, i.e. whether the proposed sharing is likely to make an effective contribution to preventing the risk and whether the public interest in sharing information overrides the interest in maintaining confidentiality. In making the decision you must weigh up what might happen if the information is shared against what might happen if it is not and make a decision based on professional judgement. The nature of the information to be shared is a factor in this decision making, particularly if it is sensitive information where the implications of sharing maybe especially significant for the individual or for their relationship with the practitioner and the service. For more on the legal background see Information Sharing: Further guidance on legal issues.

If there is a doubt whether to disclose such information the person wishing to share the information should obtain advice from their legal advisors.

4.6 Caldicott Principles

4.6.1 In January 2002 the Department of Health circular LAC (2002)2 introduced the Caldicott standards into social care. These are a set of standards designed to offer increased protection for personal data processed by health organisations and Local Authorities.

4.6.2 In April 2013 a review took place regarding Caldicott which specifically looked at to share or not to share information and was entitled Caldicott 2. As a consequence of this a seventh principle was added to the existing list of six principles.

4.6.3 There are seven principles contained within the Caldicott standards.

1. Justify the purpose for which the information is needed
2. Only use personally identifiable information when absolutely necessary
3. Use the minimum personal identifiable information possible – if possible use an identifier number rather than a name
4. Access to the information should be on a strict need to know basis
5. Everyone should be aware of his/her responsibilities to respect vulnerable adults confidentiality
6. Understand and comply with the law
7. The duty to share personal confidential data can be as important as the duty to respect service user confidentiality

4.6.4 If you are unsure how these principles relate to information sharing or you require further information you should seek the advice of your organisation’s Caldicott Guardian.
4.7 Organisational responsibility with regard to information sharing

4.7.1 Each organisation involved in the protection of vulnerable adults should have in place a mechanism for recording what information about individuals is shared. Each agency/organisation must follow any protocol prescribed by law or guidance both nationally and locally with regard to sharing information.

4.7.2 This should include:

- Adequate recording if the consent of the person was obtained and if not why not
- What information was shared and with whom and how the request was received and recorded, and how the decision was made to share the information
- If third party information is involved if consent was obtained and if not which exemptions applied
- All agencies involved must follow the appropriate statutes and guidance.
5. PROCEDURES

5.1 SETSAF - FLOWCHART

Safeguarding Process

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>SETSAF1 Received at local Adult Care / Mental Health Team</td>
<td>Information gathering commenced by Local Authority SETSAF2 COMPLETED</td>
<td>Lead agency requests information from partners</td>
<td>Information received</td>
</tr>
<tr>
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<tr>
<td>Risk Assessment of Situation based on SETSAF1 (Risk to Individual)</td>
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</tr>
<tr>
<td>No Further Action</td>
<td>Case Management</td>
<td></td>
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<tr>
<td>Go to Stage 4</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Concerns leading to the completion of a SETSAF</td>
<td>Further Information Needed</td>
<td>Safeguarding Adults Issue Identified</td>
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5.2 SET PROCEDURES TIMESCALES FOR SET SAF FORMS

- SET SAF 1 should be completed within two working days of the concern being raised. Completion of SET SAF 1 must not delay immediate action being taken where necessary to ensure the safety of the vulnerable adult and the preservation of evidence if it suspected that a crime has been committed.

- SET SAF Risk or the DASH Risk (if required) should be completed within four hours of receipt of Set SAF 1 into Social Care, where safeguard concerns have been identified.

- A visit to a service user or service should take place within a maximum of seven working days of receipt of a SET SAF 1, if after consultation it is agreed a face to face visit is not necessary, clear evidence of this decision must be recorded.

- If there are grounds to hold a safeguarding meeting (SET SAF 3), this should be done within 28 working days of the completion of SET SAF 1 – if not clearly documented reasons should be given.

- SET SAF 3 – Actions to be distributed within: 5 working days from when the safeguarding meeting took place
- SET SAF 3 distributed within: 10 working days
- SET SAF 3 – Comments and accuracy to be returned within: 5 Working days of receipt of the SETSAF3

- SET SAF 4 should be signed by the practitioners and manager within five working days of the case being closed. Referrer must be advised on outcome.

<table>
<thead>
<tr>
<th>Task</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of DASH or SET SAF RISK</td>
<td>Within 4 hours of referral being received by the local authority</td>
</tr>
<tr>
<td>Visit to service user</td>
<td>Within 7 days, unless documented reason why not appropriate</td>
</tr>
<tr>
<td>SET SAF3 Actions</td>
<td>5 working days, from when the safeguarding meeting took place</td>
</tr>
<tr>
<td>SET SAF3 Minutes</td>
<td>10 working days</td>
</tr>
<tr>
<td>SET SAF4 Signed off</td>
<td>By Day 5 after case closed</td>
</tr>
</tbody>
</table>
5.3 PRE-STAGE ONE – THE INITIAL RESPONSE – FLOWCHART – This flowchart is aimed at all staff

*Unless manager is alleged perpetrator or implicated in concern. In these circumstances identify alternative manager or discuss directly with social services.

Health Care Organisations should follow local process for reporting which integrates Clinical Governance and Safeguarding.

Ensuring the safety of the vulnerable adult and any other people at risk is the primary responsibility of staff when they become aware of a serious incident.
5.4 PRE-STAGE ONE – THE INITIAL RESPONSE – GUIDANCE

5.4.1 The first responses taken on discovering an incident has occurred or concern is raised are critical to any subsequent enquiry. In some cases the course of action is very clear, for example where a person has been subjected to a physical assault and needs immediate medical treatment for injuries, or there is an allegation of a crime.

5.4.2 It is often the less obvious cases which create concerns for staff and family on how they should be reported. These guidelines seek to assure positive action for all reports of injury, crime or concern raised on or behalf of a vulnerable adult.

5.4.3 IN ALL CASES

- Medical attention should be sought where there is a possibility that an injury may have occurred even where there are no visible signs
- Preserve all essential and vital evidence (see 5.4.4)
- Aim to minimise the risk of further harm to the vulnerable adult
- Reassure the person
- Aim to minimise the risk of intimidation by any alleged perpetrator whether known or unknown
- Obtain only sufficient information to be able to tell the police, medical personnel or management what is believed to have happened, when and where
- If a crime is being alleged contact the police
  - ‘999’ for an emergency (e.g. rape, serious physical or sexual assault, robbery),
  - The local police station or non-emergency number 101 for a crime where a safeguarding issue is not alleged/suspected (e.g. property has been stolen by another service user or the vulnerable adult has been assaulted by a neighbour when out shopping)
  - The local Central Referral Unit (CRU) if a safeguarding issue is suspected (e.g. property being stolen by a staff or family member, vulnerable adult being seen with unexplained bruises following a family visit or complaints by family of excessive force being used on a service user)
  - DO NOT interview any alleged perpetrator
- Notify manager or nominated senior person on duty as soon as practicable
- Removal of the vulnerable adult from home should not be seen as the first option to address situations of abuse (See Section 6.9 re: Out of Area Adult Safeguarding Arrangements)
- Relevant regulatory bodies must be notified when the concern relates to registered premises or services (e.g. CQC, Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR).
5.4.4 SERIOUS EVENTS OR INCIDENTS

Additional considerations
- If a **serious physical or sexual assault** is known or suspected to have happened, in order to preserve evidence:
  - The person should be advised not to wash
  - The person should be advised not to change their clothes unless essential for person’s well-being. If this is necessary put each item in a separate bag.
  - Try not to touch anything which may be a source of evidence
  - Do not tidy or remove anything from the location
  - Minimise the number of people entering the location or having contact with the vulnerable adult
- If a sexual assault is suspected or known to have happened, the person should be advised not to eat or drink anything until agreed by the police unless contrary to medical advice.
- If the vulnerable adult and alleged perpetrator are in the same location keep them separate
- Try not to allow the same person to deal with both vulnerable adult and alleged perpetrator (to prevent cross contamination)
- If the same person has had contact with both vulnerable adult and alleged perpetrator record this for the police
- If there are any witnesses record their details and give these to the police
- Secure any timekeeping sheets for duty staff to prevent them being tampered with
- Secure medical and care records for the vulnerable adult to prevent them being tampered with
5.5 STAGE ONE

SET SAF1 – Safeguarding Alert - Received

Where safeguard concerns have been identified at stage one & stage two there must be an on-going and documented RISK MANAGEMENT PLAN or the DASH RISK PLAN (if required) - http://www.essexsab.org.uk/guidelines.htm

5.5.1 SET SAF1 will be received within the local authority by the agreed local route.

5.5.2 The team receiving the SET SAF1 will (where safeguarding concerns are identified) risk assess the situation within 4 hours, giving consideration to the severity of the incident, risk to the vulnerable adult and/or others and decide on an initial course of events. Ascertaining in this process any need for immediate police referral/or checking directly with police whether a referral has already been made by another agency has been received.

5.5.3 Where the SET SAF1 is received out of office hours, the Emergency Duty Service (EDS) will undertake a risk assessment on the information received and be responsible for the co-ordinator function until a named adult care or mental health team person takes on that role on the first working day following receipt.

5.5.4 All safeguarding concerns that are processed to a referral will be nominated a case co-ordinator whose role will be:

- To assess the risk to the vulnerable adult (see ‘Risk Assessment below)
- To assess the risk to others posed by an alleged perpetrator (see ‘Risk Assessment below)
- To co-ordinate the process through to an agreed closure
- To link with the relevant manager to ratify any decisions made and if need be sign off SET SAF4
- To record the progress of the concern throughout the stages on the relevant SET SAF forms

5.5.5 When deciding if a concern should be taken through the safeguarding route the following principles and considerations should be applied:

- The nature, degree and seriousness of the alleged incident
- Whether the provider of care responded appropriately to address the concern.
- The impact upon the individual.
- The wishes of the service user (where they have capacity).
- Risk assessment based on severity and likelihood of re-occurrence.
PROCEDURES

- Whether the incident forms part of a pattern of wider concerns relating to a care provider.
- Taking in account specialist practice guidance e.g. pressure sores, medicine management.
- Complexity of the situation that warrants a multi-agency response.
- Where “poor practice” by a care provider/individual is considered as extensive (e.g. missed calls over a weekend leaving a service user in bed without food or medication).

5.5.6 Where there are concerns around the capacity of the service user the relevant MCA guidelines must be followed www.essex.gov.uk/mentalcapacityact

5.5.7 Risk Assessment - Guidance

Risks must be identified, in partnership with the vulnerable person involved in the safeguarding procedures where they have capacity, or with an appropriate person working in “best interests”.

The flowchart on page 46 identifies the process to follow in assessing and managing risk which should be initiated at the start of the safeguarding process by the most appropriate person and continuously reviewed and amended as appropriate throughout until case closure or transfer.

The risk assessment checklist is designed to prompt practitioners to identify immediate risks which need to be managed/minimised, these risks should be continually monitored and the risk assessment amended as appropriate throughout the safeguarding process.

Where it is identified that the relationship between the victim and alleged abuser constitutes a domestic abuse situation (regardless of the type of abuse) as listed on the flowchart, the DASH (Domestic Abuse, Stalking and Harassment, Honour Based Violence) Risk Model must be completed (http://www.essexsab.org.uk/guidelines.htm). In Southend, this is available on CareFirst.

If high risk is identified, consideration must be made of Police involvement if not already and a referral to MARAC (Multi Agency Risk Assessment Conference).

5.5.8 OPTIONS FOR DECISION FOLLOWING ALERT

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>No further action</td>
<td>Not a safeguarding issue, based on risk thresholds guidance below.</td>
</tr>
<tr>
<td>Information and advice given</td>
<td></td>
</tr>
<tr>
<td>Referred for case management</td>
<td>Issues are of a referral nature for</td>
</tr>
</tbody>
</table>
increased or different care which would be resolved through assessment and possible care provision.

Signposted to another agency
Where there is not a safeguarding issue but other services would be most appropriate.

Process outcome for above
Front door service (Access Team, Social Care Direct) completes box on bottom of SET SAF1 to close safeguarding as inappropriate referral.

5.5.9 Where further information is required before a decision can be made the process will move on to **STAGE TWO – INFORMATION GATHERING** and the alert becomes a referral.

5.5.10 **Safeguarding threshold model**

This model aims to try and reduce the numbers of inappropriate safeguarding concerns raised by professionals (including providers) and enable teams, to focus on the serious protection issues.

The model is based on similar models used by other local authorities who also use a threshold triangle approach. The triangle refers to all vulnerable people who live in Southend Essex and Thurrock, with each level representing their different levels of need:

- **Level 1** – universal services – people whose needs can be met through universal services (such as health, education and Police), whilst those in the levels above have additional needs.

```
  5
  4
  3
  2
  1

Serious case review
Adult safeguarding/protection
Risk assessment, risk management
Case management, reviews & complaints
Universal services
```
**PROCEDURES**

**Level 2** – complaints, case management, reviews – those who need and receive additional services from a single practitioner or agency and whose wellbeing may be affected without those services. **Low level concern.**

**Level 3** – risk assessment, risk management – those who may need an integrated multi-agency response to managing their own risk appropriately and where there is failure to manage the risk then that risk is reviewed. **Medium level concern.**

The threshold for safeguarding falls between levels 3 and 4.

**Level 4** – adult safeguarding/protection – vulnerable adults who have been placed at harm because of the actions, deliberate or unintentional, of others. There may also be a need to involve the Police. **High level concern**

**Level 5** – serious case review – those who have died as a consequence of harm or neglect and for whom the authority had responsibility. **High level concern.**

The aim of the triangle is to show a potential escalation of a person’s needs if not managed appropriately at each stage. If the situation is beyond case management and there is a risk to the individual then a safeguarding concern (SETSAF1) must be raised. When screening a SETSAF1 or any contact about a potential safeguarding issue only those that fit into level 4 should be considered as a safeguarding concern (i.e. that there is a suggestion of abuse, harm, exploitation or acts of omission – see 2.3.2).

**Service user on service user**

Incidents between service users are not always safeguarding issues. However, if there is a power imbalance between the two service users and that power imbalance is being used to one person’s advantage then this is a safeguarding issue. If there is no power imbalance then the matter is one about risk and behaviour management and should not be taken through the safeguarding route. If the incident has occurred because of the lack of support and supervision by the provider then there may be a contractual issue and the provider may be seen as neglectful, which could be a safeguarding issue, but in such a case the safeguarding concern is about the provider.

Issues that relate to contractual issues should be discussed with the relevant Commercial/Quality Improvement/Contracts Team rather than immediately raise a safeguarding concern. If there are general concerns about the quality of care within a care home then before raising a safeguarding concern there should be discussions to see if there is anything that they can do to assist the care home.

**Decision Making- is it safeguarding?**

When deciding if a concern should be taken through the safeguarding route the following principles and considerations should be applied:

- The nature, degree, seriousness of the alleged incident
PROCEDURES

- Whether the provider of care responded appropriately to address the concern
- The impact upon the individual and others at risk e.g. children
- The wishes of the service user (where they have capacity)
- Risk assessment based on severity and likelihood of re-occurrence
- Whether the incident forms part of a pattern of wider concerns relating to a care provider
- Taking in account specialist practice guidance (e.g. pressure sores)
- Complexity of the situation that warrants a multi-agency response
- Where “poor practice” by a care provider/individual is considered as extensive (e.g. missed calls over a weekend leaving a service user in bed without food or medication).

Examples

The following examples can be used to assist in decision making as to whether or not safeguarding procedures should be triggered. (NB: this is not an exhaustive list).

<table>
<thead>
<tr>
<th>Nature of concern</th>
<th>Consequence of concern</th>
<th>Action to be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Care package is not meeting service user's needs.</td>
<td>Service user's health and well-being may be at risk.</td>
<td>Review care package. Not a safeguarding issue.</td>
</tr>
<tr>
<td>2 Complaint about attitude of care staff visiting service user in their own home.</td>
<td>Service user feels uncomfortable with carer.</td>
<td>Formal complaint to be made to care agency. Not a safeguarding issue.</td>
</tr>
<tr>
<td>3 Service user in care home argues with another service user or pushes another resident.</td>
<td>Actions cause tensions between the residents.</td>
<td>Risk management plan needs to be reviewed. If this is a one-off event then it is not a safeguarding issue. If the issue is more than a one-off event and the risk is not being managed then this might be a safeguarding issue due to omission of the home to manage the risk.</td>
</tr>
<tr>
<td>4 Service user in care home physically assaults another resident.</td>
<td>Harm could be caused to another resident(s).</td>
<td>The capacity of the service user should be considered. If the alleged perpetrator has capacity and their actions deemed deliberate then the police should be informed. Risk management plan reviewed.</td>
</tr>
<tr>
<td>Procedure</td>
<td>Description</td>
<td>Potential Impact</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>5</td>
<td>Poor weather or traffic accident prevents carer from turning up on time and alternative arrangements made.</td>
<td>These are unpredictable events and as long as it is temporary and alternative arrangements made then it is not an issue. If no alternative action taken and no-one informed then this is an act of omission.</td>
</tr>
<tr>
<td>6</td>
<td>Missed call by domiciliary carer and no other contact made to check on their well-being.</td>
<td>No harm occurs.</td>
</tr>
<tr>
<td>7</td>
<td>Missed visits by domiciliary carer are a recurring event, or is happening to more than one vulnerable adult.</td>
<td>The health and well-being of the vulnerable adult is at risk.</td>
</tr>
<tr>
<td>8</td>
<td>Resident in care home has not been formally assessed with regards to pressure area management but no harm has arisen.</td>
<td>The health of the resident may not have been compromised.</td>
</tr>
<tr>
<td>9</td>
<td>Resident in care home has not been formally assessed with regards to pressure area management and ulcers have developed and may not have been dealt with appropriately.</td>
<td>The health of the resident has been placed at risk.</td>
</tr>
<tr>
<td>10</td>
<td>Service user in community or care home does not receive medication as prescribed on one occasion but no harm occurs.</td>
<td>There are no consequences of this one-off event.</td>
</tr>
<tr>
<td>11</td>
<td>Service user in community or care home does not receive medication as prescribed and it is a recurring event or has happened to more than one vulnerable person, or the absence of the one dose may be life threatening.</td>
<td>The health of the vulnerable adult is placed at risk because of the action.</td>
</tr>
<tr>
<td>12</td>
<td>Appropriate moving and handling procedures not followed but vulnerable adult does not experience harm.</td>
<td>There are no consequences of this one-off event.</td>
</tr>
<tr>
<td>13</td>
<td>One or more vulnerable adults experience harm through failure to follow correct moving and handling procedures.</td>
<td>Harm and/or injury is sustained by the vulnerable adult.</td>
</tr>
<tr>
<td>14</td>
<td>Vulnerable adult is spoken to in a rude, harsh or disrespectful manner or other inappropriate way by a member of staff.</td>
<td>The vulnerable adult is not distressed by the incident and it is believed to be an isolated incident.</td>
</tr>
<tr>
<td>15</td>
<td>Vulnerable adult is spoken to in a rude, harsh or disrespectful manner or other inappropriate way and may have occurred to other vulnerable adults.</td>
<td>Regime in the care home does not respect the dignity of the vulnerable adult and staff frequently use derogatory terms and are verbally abusive to those in their care making</td>
</tr>
<tr>
<td></td>
<td>PROCEDURES</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>16</td>
<td>Vulnerable adult in the community or a care home has an unobserved or unexplained fall. The vulnerable adult feel unsafe. There may or may not be injuries as a consequence of the fall but the reason for the fall needs to be explored (did they fall or were they pushed?). Safeguarding process should be instigated unless the person can give a reasonable explanation.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Vulnerable adult in the community or a care home has an observed or managed fall. There may be injuries which need checking out. The fall may be indicative of a decline in the person's health. Referral to GP for medical review. Risk management plan to be reviewed. Not a safeguarding issue.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Vulnerable adult in the community burgled. The incident has led to a theft. The matter is for the Police to investigate. Risk assessment needs completing. Not a safeguarding issue.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Vulnerable person victim of a deliberate hate crime or other criminal activity. They have suffered a loss of money, property or belongings or have suffered harm. The matter is for the Police to investigate. Risk assessment needs completing. Not a safeguarding issue.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Vulnerable person in care home is subject to theft or assault. They have been harmed and/or robbed. Police should be involved. Care home should investigate. Safeguarding procedures instigated.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>The failure of the heating or lift in a care home. There has to be consideration as to whether the vulnerable adult is inconvenienced or disadvantaged or left at risk of harm. If the care home takes appropriate and immediate measures then this is not a safeguarding issue. If the home fails to take remedial measures leaving the vulnerable people at risk then this could be both a contractual and a safeguarding issue.</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Failed discharge from hospital. The vulnerable adult has been discharged without, for example, pressure relief equipment, prescribed medication or without referrals to district nursing services for treatment of pressure sores being made then the vulnerable person is at risk and could become ill (and have to be re-admitted to hospital). This is an act of omission and is a safeguarding issue, especially if they subsequently need to be re-admitted.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Health deterioration Upon discharge the If the vulnerable person</td>
<td></td>
</tr>
</tbody>
</table>
following hospital discharge. vulnerable person’s health deteriorates because of their medical condition. has all the help and support etc, they need but their medical condition deteriorates then this is a medical matter not a safeguarding issue.

**RISK ASSESSMENT FLOWCHART**

CONCERN/INCIDENT REPORTED
SET SAF 1

RISK ASSESSMENT INITIATED

Is/was the relationship between the victim/alleged abuser any of the following?
- Mother/Father
- Grandparent/Great Grandparent
- Children
- Grandchildren/Great Grandchildren
- Spouse/partner
- In-laws or equivalent
- Step-family

**Yes**

Complete SET SAF Risk or DASH risk assessment if a familial relationship

If very high risk is identified consider referral to MARAC* and discuss with manager re police involvement if not already

**No**

Complete risk Assessment checklist SET SAF Risk

Risk Management Plan completed and reviewed at all stages of the process including closure and kept on Service User file

* Multi Agency Risk Assessment Conference
5.6 STAGE TWO – INFORMATION GATHERING

Where safeguard concerns have been identified at stage one & stage two, there must be an on-going and documented RISK MANAGEMENT PLAN or the DASH Risk Plan (if required) - [http://www.essexsab.org.uk/guidelines.htm](http://www.essexsab.org.uk/guidelines.htm)

5.6.1 Stage 2 is the information collection stage. This stage allows for information to be sought from the victim and all involved partner agencies to ensure an informed decision is taken about whether to move into Stage 3 - Safeguarding Meeting.

5.6.2 A SET SAF risk assessment should be reviewed on the outset of Stage 2 and throughout the stage if any relevant information comes to light that will negatively or positively impact the level of risk that the individual is exposed to. In all cases of Domestic Abuse, complete a Multi-Agency Domestic Abuse Risk Indicator score guide (DASH); follow guidance that can be found on [http://www.essexsab.org.uk/guidelines.htm](http://www.essexsab.org.uk/guidelines.htm) or [www.dashriskchecklist.co.uk](http://www.dashriskchecklist.co.uk)

For example a service user may be subject to abusive behaviour by a partner but does not want the police involved. Where the identified risk to the vulnerable adult is not at the very high level, their wishes should be respected as far as possible. However where the identified risk of significant harm is very high then the service user must be advised that information will be shared with the police in order for them to consider the safety of that individual and whether an investigation is appropriate.

In all cases:

5.6.3 SET SAF1 notification to be sent to police (CRU), if the possibility of a crime is suspected and either there is consent of the victim to share (if uncertain, check with the police if they are aware of the referral):

- or the situation surrounding the allegation meets the threshold for information sharing as set down by the public interest test
- or where a vulnerable adult may be suffering or may be at risk of suffering serious harm, for more information please see the information sharing section on page 28.

Examples could be:

- Allegation of theft of money by a carer
- Allegation of assault due to excessively rough handling within a care setting
- Persistent unexplained bruising on a person who is being cared for by a relative (see also section on Risk Assessment – page 39)
- Untreated pressure ulcers on a person within a care setting.

Where consent to share information should not be sought:

There will be some circumstances where you should not seek consent from the individual or their family, or inform them that the information will be
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shared, for example, if doing so would:

- place a person (the individual, family member, yourself or a third party) at increased risk of significant harm (if a child), or serious harm (if an adult); or
- prejudice the prevention, detection or prosecution of a serious crime; or
- lead to an unjustified delay in making enquiries about allegations of significant harm to a child or serious harm to an adult.

5.6.4 Case co-ordinator should define the parameters of the information gathering process in consultation with their manager and decide the actions to be taken considering the checklist below:

- Consider the need to carry out a Mental Capacity Assessment, if an IMCA needs to be commissioned. Consult local MCA guidance
- Ensure that the vulnerable adult’s continuing safety is assured
- Complete SET SAF2 detailing the information gathering process
- All discussions and decisions should be recorded within 2 working days
- Identify and contact relevant agencies to the case
- Review current risk assessment of the situation based on incoming information
- Ensure that CQC and other regulatory agencies are notified in writing of SET SAF1 forms received relating to registered premises or services as required
- Consider whether to ask agency/provider to commence an internal investigation if required
- If alleged perpetrator is employed by an individual purchasing their own care or by an agency, is any disciplinary action being considered or undertaken
- Is legal advice required?
- Service commissioners need to be involved
- If there is a police investigation, contact the officer in charge of the investigation to discuss procedures and actions

5.6.5 Where the offence is thought to be serious the police should be called as shown in the guidance notes for Pre-Stage One – The Initial Response. The vulnerable adult will then be able to speak to the police and discuss what further action is to be taken. The more serious the potential offence the greater the requirement to notify the police as soon as it is discovered. For example if a staff member discovers a service user very distressed following a recent serious assault the police should be called immediately and the service user told that this has happened.

5.6.6 If there is evidence of a crime the police will decide whether it is a vulnerable adult abuse case and will arrange for it to be dealt with by the appropriate staff. If there is no identified offence they will advise the lead agency
PROCEDURES

accordingly. In all cases they will reply to the originator by e-mail with the decision within seven days of being sent the notification.

5.6.7 Collate information received and, in consultation with their manager, decide whether the case is to be finalised at the end of STAGE TWO or if it should continue to STAGE THREE – SAFEGUARDING ADULTS MEETING.

5.6.8 Complete SET SAF4 if no further action or case management decision.

5.6.9 It is good practice for the informant to be advised of the general outcome e.g. “We have considered your call and appropriate action is being taken.” Where this is not possible the reason must be recorded on SET SAF4.

5.6.10 Coordinate the move to STAGE 3 if evidence of safeguarding adult issue.

5.6.11 The police will be responsible for investigating any criminal allegations and will be responsible for liaising with the case coordinator to keep them appraised of their investigation.

5.6.12 During this stage organisations may be carrying out their own internal enquiries. This should be co-ordinated with the safeguarding adult process, but may be linked by information gathering and sharing.

5.6.13 Internal enquiries may be suspended where the police request such action, or where the organisation is unable to progress due to competing priorities between civil and criminal proceedings. For example a disciplinary hearing may not be possible until the conclusion of a police investigation in order not to prejudice any possible prosecution.

5.6.14 Any statements taken during the course of an internal enquiry remain the property of the person making it and their organisation. It can only be shared with the informed consent of the person making it, by a court order or under a relevant provision of the Data Protection Act 1998 (e.g. where an employee has been interviewed as an alleged perpetrator by their employer as part of an internal enquiry).

5.6.15 **Liaison with the service user or representative is essential** and their wishes should be considered at all stages of the process. For further information see page 39 ‘Risk Assessment’ and page 28 ‘Information Sharing’.
5.7 STAGE THREE - SAFEGUARDING ADULTS MEETING

At all stages there must be an on-going and documented RISK MANAGEMENT PLAN or the DASH RISK PLAN (if required) - http://www.essexsab.org.uk/guidelines.htm

Adult Safeguarding meetings are held when more than two people are involved in a discussion about a safeguarding case. Typically meetings are held to plan the investigation of safeguarding cases, discuss and agree the on-going actions from cases or to review and close. This could be done virtually or by telephone, a SET SAF 3 will need to be completed for these meetings.

5.7.1 Stage three is considered when the information gathering identifies there is evidence that there is a safeguarding issue which requires a multi-agency meeting to be held to take issues forward.

5.7.2 This process runs parallel to any police or other investigation; however information from some agencies may be restricted dependent on the stage of their enquiry.

<table>
<thead>
<tr>
<th>Who is responsible?</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Coordinator</td>
<td>Secure a chair.</td>
</tr>
<tr>
<td></td>
<td>Secure a minute taker.</td>
</tr>
<tr>
<td></td>
<td>Book a room and adapt it accordingly for needs and safety.</td>
</tr>
<tr>
<td></td>
<td>Notify attendees of the meeting arrangements.</td>
</tr>
<tr>
<td></td>
<td>For letter templates see Appendix 3.</td>
</tr>
<tr>
<td></td>
<td>Arrange for receipt of all reports before meeting, ensuring that the Chair sees them.</td>
</tr>
<tr>
<td></td>
<td>Act as a central point of contact for updates on actions and additional information.</td>
</tr>
<tr>
<td></td>
<td>Provide the updated SET SAF2 and SET SAF risk assessment to the chair prior to the meeting for their information.</td>
</tr>
<tr>
<td></td>
<td>If action needs to be passed to an agency not present the case coordinator must ensure this takes place.</td>
</tr>
<tr>
<td></td>
<td>Update the service user and/or their representative regarding the outcome of the meeting if they have not been in attendance.</td>
</tr>
<tr>
<td>Administrator</td>
<td>To record actions and minutes and prepare drafts for chair to proof within timescales.</td>
</tr>
<tr>
<td></td>
<td>Minutes should be summaries of</td>
</tr>
</tbody>
</table>
Joint (Chair/Case Coordinator) | Agree together:
| o Purpose of meeting
| o Attendees required
| o Agenda
| o Guidance on who should be invited and when
| o When the suspected perpetrator/provider/family should be invited or not

It will be the responsibility of the case co-ordinator to carry out all agreed arrangements.

Chair | Review the updated SET SAF2 and SET SAF risk assessment provided by case coordinator.
| Set an agenda and ground rules.
| Consider meeting with the service user/family in advance of the meeting to set the context and expectations regarding the meeting.
| Carry out an Outcome Questionnaire if required.
| Agree the outcomes of the meetings with all parties and ensure that disagreements are recorded.

All meeting attendees
| Pending circulation of the draft meeting notes, individuals should record and initiate their own actions.
| Agencies will be responsible for making notes of what is relevant to them during the meeting, their agreed actions and timescales.
| Proof the actions and the minutes.

5.7.3 The SET SAF3 should be used as the standard format to record the meeting and will include:
- list of attendees
- summary of original concern
- notes of information shared and by which agencies
- agreed action points with timescales
- trigger to update SET SAF risk assessment
- names of people who have responsibility for these actions
- list of attendees and apologies received

5.7.4 Notes and actions of the meeting are to be circulated within the following time scales:

<table>
<thead>
<tr>
<th>Action</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions distribution</td>
<td>Within 5 working days</td>
</tr>
<tr>
<td>SET SAF 3 distribution</td>
<td>Within 10 working days</td>
</tr>
<tr>
<td>Comments concerning accuracy or alternations to be returned</td>
<td>Within 5 working days of circulation of draft SET SAF 3</td>
</tr>
</tbody>
</table>

5.7.5 The adult safeguarding meeting is confidential. The SET SAF3 can only be distributed to those agency members attending or invited to attend, other designated managers whose names shall appear on the distribution list on the front of the SET SAF3.

5.7.6 Agencies must be advised in advance who will be present at any stage of the meeting. Depending on the circumstances it may be appropriate to hold the meeting in separate parts, with the victim/victim representative(s) and the alleged perpetrator(s)/representative(s) are present (separately) and the second part where they are not.

5.7.7 During a police investigation it is not permissible for the police to engage with an alleged perpetrator outside the criminal justice process. Therefore the police will not attend meetings or parts of meetings where the alleged perpetrator or representative is present.

5.7.8 At the end of a meeting the Chairperson must ensure agreed outcomes. Where there are actions identified and if a further meeting is required this will remain within the scope of Stage Three until all the review meetings are concluded.

5.7.9 Where there are concerns around the capacity of the service user the relevant MCA guidelines must be followed.

5.7.10 If there are to be no further Safeguarding Adult Meetings the outcome from outstanding actions will be recorded on SET SAF4 under **Stage Four – CASE CLOSURE**.
5.8 STAGE FOUR - CASE CLOSURE

At all stages there must be an on-going and documented RISK MANAGEMENT PLAN or the DASH RISK PLAN (if required) - http://www.essexsab.org.uk/guidelines.htm

Stage 4 is the stage of the process that closes the case. Cases can be closed at any stage in the process where it is agreed that there are no longer safeguarding issues to be considered or that can be managed through case management.

Case Conclusion Outcomes for SET SAF 4 - Definitions

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantiated</td>
<td>All allegations of abuse can be proven on the balance of probabilities then the case conclusion should be recorded as Substantiated.</td>
</tr>
<tr>
<td>Partly Substantiated</td>
<td>Some but not all allegations of abuse can be proven on the balance of probabilities then the case conclusion should be recorded as Partly Substantiated.</td>
</tr>
<tr>
<td>Not Substantiated</td>
<td>All allegations of abuse can be disproven on the balance of probabilities then the case conclusion should be recorded as Not Substantiated.</td>
</tr>
<tr>
<td>Not Determined / Inconclusive</td>
<td>An investigation could not reach a conclusion as to whether the allegations are true or false on the balance of probabilities then the case should be recorded as Not Determined / Inconclusive. Referrals should also be recorded as Not Determined / Inconclusive where the investigation is stopped before it is fully completed.</td>
</tr>
<tr>
<td>Investigation ceased at individual’s request</td>
<td>An individual at risk does not wish for an investigation to proceed for whatever reason which precludes a conclusion being reached. Referrals which proceed despite this, for example where a local authority has a duty of care to protect other residents e.g. in a care home setting will not come under this definition.</td>
</tr>
</tbody>
</table>
5.8.1 Case closure can occur after each stage of the process. At **Stage One** there are four options. SET SAF 4 must be completed in line with guidance (see 5.8.4 – 8 below).

<table>
<thead>
<tr>
<th>Stage One</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>a) Safeguarding issue to be investigated.</td>
<td>Proceed to SET SAF risk assessment and SET SAF2.</td>
<td></td>
</tr>
<tr>
<td>b) No further action.</td>
<td>Complete the box on SET SAF1.</td>
<td></td>
</tr>
<tr>
<td>c) No further action and referral to another agency.</td>
<td>Complete the box on SET SAF1.</td>
<td></td>
</tr>
<tr>
<td>d) Not a safeguarding matter. Case management resolution.</td>
<td>Complete the box on SET SAF1.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage Two</th>
<th></th>
<th>Completion of SET SAF2 and Risk Assessment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding investigation.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage Three</th>
<th>Option 1: A further safeguarding meeting and/or on-going intervention is required.</th>
<th>Convene another meeting. Complete SET SAF3.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Case to remain within STAGE THREE until the decision is made to close the concern.</td>
<td></td>
</tr>
<tr>
<td>Option 2:</td>
<td>The issues are no longer that of safeguarding nature and can be closed.</td>
<td>Complete a SET SAF3 and a SET SAF4.</td>
</tr>
</tbody>
</table>

5.8.2 Following a Safeguarding Adults Meeting there are two options;

A. A further safeguarding meeting and/or on-going intervention is required.

B. The issues are no longer that of safeguarding and can be closed.

Under Option A: - Where there is to be a further meeting and/or intervention, the process will remain within STAGE THREE until the decision is made to close the concern.

Under Option B: Where the concern is to be closed, this will be endorsed on the notes of the meeting by the Chairperson along with any further actions required. These could be:

- Having considered all the information there is no evidence of a safeguarding issue and there is to be no further action
- All actions required to safeguard the service user have been carried out, or are in the process of being carried out and no further action is required
PROCEDURES

- The concern is being addressed or monitored through case management
- Civil or police proceedings are taking place which are no longer impacting on the safeguarding issues
- The concern has is no longer a safeguarding issue and a single agency has taken responsibility for the on-going case management
- Any other outcome, which must be specified on SET SAF4.

5.8.3 **When decision to close the case is made, the case co-ordinator will inform:**

- Service user (and/or representative) is to be notified of the outcome of the concern and any on-going issues relevant to their case management. Including risk management plans and review arrangements.
- The referrer must be advised of the general outcome. Where this is not possible the reason must be recorded on SET SAF4.
- Alleged perpetrator should be advised of the closure of the safeguarding aspect (although this may be on-going with other agencies).

5.8.4 On completion of the SET SAF4 the following must be carried out:

- Risk management plan updated or finalised
- Review date set where required/appropriate
- The decision must be authorised by the relevant manager

5.8.5 SET SAF4 must then be sent to the agreed location through the local process.
6. ADDITIONAL PROCEDURES

6.1 DOMESTIC VIOLENCE AND ABUSE

The definition of domestic abuse used by the Home Office and most agencies is:

Any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim (March 2013.)

6.1.1 Domestic abuse is about the power and control of one person over another. The abuse can take many forms, but is sometimes classified under headings including:

- Making threats
- Intimidation
- Economic / financial abuse
- Using isolation
- Emotional abuse
- Taking domineering role in the partnership
- Using the children
- Minimising /denying own behaviour
- Physical / sexual violence

6.1.2 The links between abuse of vulnerable adults and domestic abuse are clear in the similarities between the types of abuse experienced. Incidents can be considered as both domestic and vulnerable adult abuse when the perpetrator is, for example, both daughter and carer to the vulnerable person.
6.1.3 It is the familial relationship between the people involved which makes an incident or series of events ‘domestic abuse’.

6.1.4 Domestic abuse is a complex issue, vulnerable adults, who are victims, may remain with an abusive partner for many years suffering emotional, physical or other abuse without considering leaving or recognising that they are living within an abusive relationship. They cannot be forced to leave an abusive situation, but consideration must always be given to offering appropriate support and sign posting, where possible, ensuring the safety and protection of the person being abused. Domestic abuse can happen where a vulnerable adult is being cared for by a child, grandchild, sibling or parent. It is not confined to intimate relationships or partnerships.

6.1.5 People working with vulnerable adults may regularly encounter situations of domestic abuse. They must be careful not to judge the people involved and must take action appropriate to their organisation. Where a service user has disclosed domestic abuse to a worker/volunteer then that person has a responsibility to consider the risk to the vulnerable adult/victim and balance that against how the service user wants the matter dealt with. However all allegations of domestic abuse must be recorded within the vulnerable adults records in case of further reports or serious incident. Each agency should have a process by which allegations of domestic abuse are recorded along with actions taken.

6.1.6 Where the indication of risk to the vulnerable adult is very high, there is an absolute requirement to take positive action to protect the vulnerable adult and this will almost certainly require information to be shared with other agencies. For more information about risk assessment see page 39 and for Information Sharing see Page 28.

6.1.7 Where the risk identified to the victim is very high then consideration may be given to referring the victim to a Multi-Agency Risk Assessment Conference (MARAC) in addition to any other processes. MARAC is a victim focused process in which the needs of the victims in domestic abuse cases and the risks posed by the alleged perpetrator are considered in a multi-agency forum and a joint safety plan is constructed around the individual. The MARAC works in conjunction with, and supports, the normal safeguarding processes outlined in this guidance.

6.1.8 Common examples of abusive relationships and how risk can be considered are:

- A husband and wife have been together for many years and she is now suffering from dementia. The care worker sees bruising on her arms and reports this to the Adult Social Care Team.

  A care plan assessment shows that he is having severe troubles coping with his wife’s increasing needs and does not know how to safely lift or restrain her. The wife has said that she does not want the police involved.
as she wants him to care for her. Additional support and instruction is provided to the husband and the situation is resolved.

The risk indication for this case would show that although this fits the definition of domestic abuse, the risks can be significantly reduced by effective case management. It can be dealt with on a single agency basis without the need to share information against the wife’s wishes.

- An 80 year old widow’s son returns home after his marriage breaks down, she has mobility issues and has adaptations provided through social care in her home. He demands money from his mother over a period of time, threatening her when she protests and when she finally refuses he violently assaults her leading her to be hospitalised for 2 days due to serious bruising across her face and body. She refuses to report it to the police because he is her son and she does not want to criminalise him.

The risk indication for this case would show that there is a high risk to the vulnerable adult, the injuries suffered are severe, the assault has followed escalation of abuse over a short time, he is controlling, has money issues and there may well be other background issues. There is a need in this case to consider positive action to support and protect this lady. She may need advice on removing him from the home without going to the police. Due to the risk to the vulnerable adult, notifying other agencies without consent is a possibility in order to obtain information about the risks and options available to provide her with support and protection.

6.1.9 Disability

- Disabled adults are at increased risk of experiencing domestic abuse compared to non-disabled adults and from a wider range of other adults, including carers
- Disability of victims often increases their dependency on the perpetrator for care and for meeting their basic needs. This can be exploited by the perpetrator, making it harder for the victim to leave. It is also hard for a survivor to leave a home or care package that has been specially designed or adapted to meet their needs
- Survivors of domestic abuse who have a disabled child or dependent adult may also find it difficult to leave a perpetrator who is also a carer for child or dependent adult or to leave a home or system of care which meets their needs
- Survivors of domestic abuse who are being abused by a perpetrator who is disabled, or disabled people who are being abused by a carer, may find it hard to be believed as this contradicts many stereotypical views of disabled people and of carers
- A disabled child or dependent adult may have a statement of special needs made by local authority social care. This may take time to transfer if the victim and children leave the area or home. It may also be the cause of the perpetrator discovering where they live, if they are informed of the transfer. This is possible if the perpetrator is the other parent
6.1.10 Safety Planning

Safety planning for survivors, children and other people at risk is crucial to all interventions to safeguard vulnerable adults affected by domestic abuse.

Safety planning will need to take place whether or not the survivor is still living with or in a relationship with the perpetrator. Because of the risks involved in separation, safety planning will usually need to increase in strength and intensity around and after separation. It is crucial that separation is NOT seen as the only or essential element in safety planning.

Survivors of domestic abuse, children and other people at risk, will almost always have developed their own safety strategies, and all immediate and subsequent assessments of the risk to these individuals should include assessing the strategies they currently use or have thought of.

Practitioners should always refer to the guidance and templates in the full procedures, and consult with specialist agencies, when developing safety plans with victims and vulnerable adults.

6.2 MARAC (Multi Agency Risk Assessment Conference)

6.2.1 MARAC is a formal multi-agency meeting to consider and safety plan for the highest risk victims of domestic abuse, their children and vulnerable adults living in the household. The purpose of MARAC is for partners to attend and share relevant and proportionate information on those victims identified as being at a ‘high’ level of risk of serious harm or homicide and thereafter jointly constructing a management plan to provide professional support to all those at risk within the family.

6.2.2 Such meetings will be held on a regular basis as required. Each MARAC covers a specific area of Essex, this means that currently there are 6 MARAC’s covering the Essex Police area each meeting on a regular basis.

6.2.3 Each partner agency will nominate individuals who will have access to the information provided at MARAC and attend MARAC on behalf of their organisation. Information shared at MARAC must be kept in a confidential and appropriately restricted manner and must not be shared with other agencies without the permission of the agencies attending that MARAC.

6.2.4 The full information sharing agreement and working practices for MARAC can be found on local intranet sites where appropriate or caada - co-ordinated action against domestic abuse.

6.2.5 The purpose of MARAC is to:

- Share relevant information to increase the safety, health and well-being of victims – adults and their children;
6.3 Honour Based Abuse (HBA)

Forced Marriage Unit at the Home Office defines honour based violence in the following way:

“So-called honour based violence is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community”

All practitioners working with victims of forced marriage and violence in the name of honour need to be aware of the "one chance" rule. That is, they may only have one chance to speak to the potential victim and thus they may only have one chance to save a life. This means that all practitioners working within statutory agencies needs to be aware of their responsibilities and obligations when they come across these cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted.

HBA can manifest in many different ways and often presents with accompanying criminal offences, domestic abuse or the civil offence of forced marriage. If incidents include domestic abuse, missing persons, child abuse or other serious crime then it should be read in conjunction with the relevant policies and procedures on these subjects.

Honour” is normally associated with cultures and communities from Asia, the Middle East and Africa as well as the Travelling Community. In reality it cuts across all cultures, nationalities, faith groups and communities and transcends national and international boundaries.

The ‘honour code’ means that women generally, but sometimes males, must follow rules that are set at the discretion of the male relations and which are interpreted according to what each male family or community member considers acceptable.

It must be noted that in most cases, the Police should take the lead for any HBA incidents. In those cases, much of the following guidelines in terms of procedures would be the responsibility of the lead organisation and not Social Services. However, a victim may be known to Social Services as a vulnerable adult or child and joint working with police and other organisations required.

Also, a victim may approach Social Care or another Council Service in the first instance, yet they may not be under 18 and/or may not have a disability
or condition that would ordinarily meet eligibility criteria as a vulnerable adult. In such cases, it is important that you do not ‘turn the individual away’. You need to ensure their immediate safety and support them to make urgent and safe contact with Police.


6.4 Forced Marriage

The Home Office definition of forced marriage is:

'A marriage without the consent of one or both parties and where duress is a factor'.

The Court of Appeal clarified that duress is: 'when the mind of the applicant has been overborne, howsoever that was caused'.

An arranged marriage is very different from a forced marriage. An arranged marriage is entered into freely by both people, although their families take a leading role in the choice of partner.

A forced marriage is where one or both people do not (or in some cases of people with learning or physical disabilities, cannot) consent to the marriage and pressure, coercion or abuse is used.

The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they’re bringing shame on their family). Financial abuse (taking your wages or not giving you any money) can also be a factor.

Marriages within communities that believe in protecting the ‘honour’ of their family are a significant event. Marriage contracts will often be drawn up when children are young and are seen as a binding arrangement between the two families. If one or both parties then seek to disengage from the contract it is seen as bringing great shame on the family and very contentious.

Forced marriages can occur in this country or abroad, often in their country of origin. For further information on Forced Marriage follow the link: [https://www.gov.uk/forced-marriage](https://www.gov.uk/forced-marriage).

6.5 PREVENT

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

There are a number of factors that should not be considered in isolation but in conjunction with the particular circumstances of the individual: identity or personal crisis, particular personal; circumstances, unemployment or underemployment and criminality. All of these may contribute to alienation from UK values and a decision to cause harm to symbols of the community or the state.

**CONTEST** is the national counter terrorism strategy. The aim of **CONTEST** is to reduce the risk to the United Kingdom and its interests overseas from international terrorism, so that people can go about their lives freely and with confidence. The Office for Security and Counter Terrorism (OSCT) is responsible for providing strategic direction and governance on CONTEST.

The strategy has four work streams:

1. **Prevent**: to stop people becoming terrorists or supporting terrorism
2. **Pursue**: to stop terrorist attacks
3. **Protect**: to strengthen our protection against terrorist attack
4. **Prepare**: where an attack cannot be stopped, to mitigate its impact

**Prevent** is to stop people from becoming terrorists or supporting terrorism. The objectives of the strategy are to:

1. Respond to the ideological challenge of terrorism and the threat we face from those who promote it.
2. Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.

Work with sectors and institutions where there are risks of radicalisation which we need to address. The **Channel** programme was developed as a key part of the Prevent strategy. **Channel** is a Home Office funded programme to utilise the existing partnership working between the police, local authority and the local community to identify those at risk of being drawn into terrorism or violent extremism and to provide them with community-based interventions. There is guidance for local implementation. Prevent will address all forms of terrorism but continue to prioritise according to the threat posed to our national security.

### 6.6 INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCAs)

6.6.1 The MCA Regulations extend the powers of local authorities and National Health Service (NHS) to instruct IMCA’s in certain cases of adult safeguarding. There is a duty on local authorities and the NHS to decide
which clients would most benefit from IMCA support. It is unlawful not to consider the use of an IMCA in these circumstances.

6.6.2 The Regulations specify that LA’s and NHS have powers to instruct an IMCA before a decision is made if the following two requirements are met:

- Where protective measures are being put in place in relation to the protection of vulnerable adults from abuse; and
- Where the person lacks capacity.

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

6.6.4 An IMCA can be appointed if the person has no friends or relatives. An IMCA can also be appointed if friends or family are unwilling or unable to support the decision making process or are involved in the alleged abuse.

6.6.5 The Regulations apply to those who have been abused, been neglected or are the alleged abuser or also have the services of an advocate.

6.6.6 The power to instruct an IMCA must be looked at in each individual case if they satisfy the requirements. The IMCA may be required to interview the person in private, examine records, consult professionals, friends and family, which should be supported and facilitated by the agencies concerned. If an IMCA is instructed then the LA and/or NHS body must take into account any information or submission made by the IMCA in their report, including possible alternative courses of action when reaching any decision about protective measures for the vulnerable adult.

6.7 Deprivation of Liberty Safeguards (DoLS 2007)
( amendment of the Mental Capacity Act 2005)

The Deprivation of Liberty Safeguards were introduced via the revision of the Mental Health Act 1983 in 2007. The amendments to the Mental Capacity Act 2005 strengthen the protection of a very vulnerable group of people and tackle human rights incompatibilities by introducing safeguards for people lacking capacity to decide about their accommodation and care needs in hospitals and care homes.

This legislation is largely the result of what is known the Bournewood case (HL v UK) which was heard in the European Court of Human Rights in 2004 and highlighted a breach of Article 5 of the European Convention. The upshot of the case was that HL was effectively being detained without any consent and with no procedural rules. Therefore, it was an unlawfully detention with no legal safeguards, especially the right to appeal against his detention.

The Deprivation of Liberty Safeguards (DoLS) were implemented in April 2009. These apply to people over the age of 18 in hospitals and care homes. The person must have a mental disorder and is likely to receive care in
circumstances that amount to deprivation of liberty. These criteria will be fully assessed by independent assessors who must examine whether or not this is a proportionate response to the situation, bearing in mind the best interests of the person. A series of 6 assessments will take place before recommendations are made to the PCTs or the Local Authorities who act as Supervisory Bodies.

The role of the Best Interests Assessor is to analyse the full circumstances of a case and be able to evidence what constitutes deprivation versus permissible restrictions within the wider remit of the Mental Capacity Act 2005.

The safeguards introduced by the legislation enable Representatives or IMCAs (Independent Mental Capacity Advocate) to take the matter to court, should they object /disagree with the Supervisory Body’s decision.

People who are legally deprived of their liberty are closely monitored through a system of reviews to ensure ongoing compliance with law. The Managing Authorities (Care homes or hospitals) have also got responsibilities all through the process to ensure that the safeguards are being implemented in an effective and lawful manner.

6.8 WHISTLE BLOWING (CONFIDENTIAL ALERTERS)

6.8.1 A whistle blower is an employee, a former employee or member of an organisation especially a business or government agency who reports misconduct to people or entities that have the power and presumed willingness to take corrective action.

6.8.2 Each organisation should have its own policy/guidance with regard to whistleblowing. Staff must be made aware of these policies which should be in an easily accessible location for staff reference.

6.8.3 It is good practice, and staff have a duty of care, to draw attention to bad/poor practice in the workplace. This includes practice that may be abusive and/or neglectful. **Failure to report amounts to collusion with the perpetrator and abuse.**

6.8.4 Staff who work with vulnerable adults have an individual responsibility to raise concerns with someone who has the responsibility to take action. Sometimes it may be necessary to go outside the immediate work environment or the immediate organisation.

6.8.5 It is the responsibility of all organisations to promote a culture which values good practice and encourages whistle blowing.

6.8.6 People have in the past often been deterred from `whistle blowing` about abuse or neglect by duties of confidentiality and/or fear of the consequences of speaking out. The Public Interest Disclosure Act 1998 seeks to protect disclosure of the following:
ADDITIONAL PROCEDURES

- Criminal offence (past, ongoing or prospective) failure to meet a legal obligation miscarriage of justice health and safety being endangered
- Risk of environmental damage, or
- Deliberate concealment of any of the above.

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

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

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

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

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

6.8.11 Disclosure to a third party has to be a ‘reasonable’ step in all the circumstances including:

- Whom one tells (e.g. disclosure to a statutory inspectorate in preference to the press);
- How serious the concern is, and whether it is a continuing problem;
- Whether the employer has a whistle blowing procedure and if so, whether the employer has followed it.

6.8.12 It may be justified for the whistle blower to disclose to a third party in the first instance rather than the employer.

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

- A confidentiality clause in an employment contract cannot be used to prevent one from disclosing relevant breaches of the law or practice. This means that confidentiality terms in employment contracts cannot be used by employers who are responsible for breaking a law or for abuse or neglect or other malpractice
- Dismissal on grounds of disclosure within the terms of the act is automatically unfair, and can be challenged before the employment tribunal.
ADDITIONAL PROCEDURES

6.8.14 Someone who is treated detrimentally at work because of making a disclosure, which is protected by the Act, may be able to claim compensation at an Employment Tribunal.

6.8.15 The person providing the information may be reluctant to give their name or they may ask that they remain anonymous. Their wishes will be recorded and respected as part of the referral process. Whilst respecting their right to confidentiality, they cannot however be given an absolute undertaking that they will not be identified at a later date, especially, if any legal action is indicated.

There are a myriad of different helplines available nationally (CQC, NHS, GMC, etc.) to assist staff if required.

6.9 OUT OF AREA ADULT SAFEGUARDING ARRANGEMENTS

The Association of Directors of Adult Social Services produced a protocol in December 2012 for Inter-Authority Safeguarding Adults Investigation and Protection Arrangements. The protocol is based on 6 principles:

1. The host authority (the local authority or NHS body in the area where the abuse occurred) will have overall responsibility for co-ordinating the safeguarding adult’s investigation and for ensuring clear communication with all placing authorities and other stakeholders, especially with regards to the scheduling of meetings and the planning of the investigation.

2. The placing authority (the local authority or NHS body that has commissioned the service for an individual involved in a safeguarding adult’s allegation) will have a continuing duty of care to the vulnerable adult or adult at risk of harm that they have placed.

3. The placing authority will contribute to the investigation as required, and maintain overall responsibility for the individual they have placed.

4. The placing authority should ensure, through contracting arrangements and in service specifications, that the provider has arrangements in place for protecting vulnerable adults or adults at risk of harm and for managing concerns, which in turn link with local (host authority) multi-agency safeguarding adults policy and procedures. This includes the requirement to inform the host authority of both individuals and placing authorities affected by the safeguarding concerns.

5. Authorities may negotiate flexible arrangements, for example relating to another authority undertaking assessments, reviews, investigative activities or other supportive activities on behalf of a placing authority. In such cases, the placing authority would maintain overall responsibility for the person they have placed, and reimbursement would be required and agreed as part of such negotiations.

6. Providers of care and support services have rights and responsibilities, and may be required to undertake their own investigations. The host
authority must ensure effective and timely communication with the provider of care throughout the investigation.

A full copy of the guidance can be found at http://adass.org.uk/images/stories/Policy%20Networks/Safeguarding_Adults/Key_Documents/ADASS_GuidanceInterAuthoritySafeguardingArrangementsDec12.pdf
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ADASS</td>
<td>Association of Directors of Adult Social Services</td>
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<td>AMPHs</td>
<td>Approved Mental Health Practitioners</td>
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<td>BSL</td>
<td>British Sign Language</td>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CRU</td>
<td>Central Referral Unit incorporating Domestic Abuse and Hate Crime (Essex Police)</td>
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<tr>
<td>DASH</td>
<td>Domestic Abuse Stalking, Harassment and Honour Based Abuse</td>
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<tr>
<td>DoLS</td>
<td>Deprivation of Liberty Safeguards</td>
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<td>DBS</td>
<td>Disclosure and Barring Service</td>
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<td>DWP</td>
<td>Department for Works and Pensions</td>
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<td>Emergency Duty Service</td>
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<td>FGM</td>
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<td>FMPO</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HBA</td>
<td>Honour Based Abuse</td>
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<td>Health Care Commission</td>
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<td>IMCA</td>
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<td>MARAC</td>
<td>Multi-Agency Risk Assessment Conference</td>
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<tr>
<td>MCA</td>
<td>Mental Capacity Act 2005</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act 1983</td>
</tr>
</tbody>
</table>
## Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>OPG</td>
<td>Office of the Public Guardian</td>
</tr>
<tr>
<td>POA</td>
<td>Power of Attorney</td>
</tr>
<tr>
<td>RIDDOR</td>
<td>Reporting of Injuries, Diseases &amp; Dangerous Occurrences Regulations</td>
</tr>
<tr>
<td>SAF</td>
<td>Safeguarding Adults Form</td>
</tr>
<tr>
<td>SET</td>
<td>Southend Essex &amp; Thurrock</td>
</tr>
</tbody>
</table>
| Social Services | Department of People (Southend)  
|              | Adult Operations (Essex)  
|              | Adult Social Care (Thurrock) |
| SLA          | Service Level Agreement |
## APPENDIX 1: CONTACT DETAILS

Completed forms should be sent to your relevant Local Authority:

<table>
<thead>
<tr>
<th>Southend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By Email:</strong></td>
</tr>
<tr>
<td>Secure email only: <a href="mailto:accessteam@southend.gcsx.gov.uk">accessteam@southend.gcsx.gov.uk</a></td>
</tr>
<tr>
<td>Please note you can only send emails to the secure address if you are sending from a secure email</td>
</tr>
<tr>
<td>Non Secure email: <a href="mailto:accessteam@southend.gov.uk">accessteam@southend.gov.uk</a></td>
</tr>
<tr>
<td><strong>By safe haven Fax to:</strong> 01702 534794</td>
</tr>
<tr>
<td><strong>Making a referral/enquiry by telephone:</strong> Access Team: 01702 215008</td>
</tr>
<tr>
<td><strong>Out of hours Referrals:</strong></td>
</tr>
<tr>
<td>General Public - 0845 606 1212</td>
</tr>
<tr>
<td>Statutory Agencies – 0300 123 0778</td>
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<tr>
<td>Fax - 0300 123 0779</td>
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</table>

<table>
<thead>
<tr>
<th>Essex</th>
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<tbody>
<tr>
<td><strong>By Post to:</strong> Essex Social Care Direct, Essex House, 200 The Crescent,</td>
</tr>
<tr>
<td>Colchester, Essex, CO4 9YQ</td>
</tr>
<tr>
<td><strong>By email:</strong></td>
</tr>
<tr>
<td>Secure email only: <a href="mailto:essexsocialcare@essex.GCSX.gov.uk">essexsocialcare@essex.GCSX.gov.uk</a></td>
</tr>
<tr>
<td>Please note you can only send emails to the secure address if you are sending from a secure email address</td>
</tr>
<tr>
<td>Non Secure email: <a href="mailto:Socialcaredirect@essex.gov.uk">Socialcaredirect@essex.gov.uk</a></td>
</tr>
<tr>
<td><strong>Making a referral/enquiry by telephone:</strong> 0845 603 7630</td>
</tr>
<tr>
<td><strong>By safe haven fax to:</strong> 0845 601 6230</td>
</tr>
<tr>
<td><strong>Out of hours Referrals:</strong></td>
</tr>
<tr>
<td>General Public - 0845 606 1212</td>
</tr>
<tr>
<td>Statutory Agencies – 0300 123 0778</td>
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<td>Fax - 0300 123 0779</td>
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<th>Thurrock</th>
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<tr>
<td><strong>By Email:</strong></td>
</tr>
<tr>
<td>Secure email only: <a href="mailto:SafeGuardingAdultsTeam@thurrock.gcsx.gov.uk">SafeGuardingAdultsTeam@thurrock.gcsx.gov.uk</a></td>
</tr>
<tr>
<td>Please note you can only send emails to the secure address if you are sending from a secure email</td>
</tr>
<tr>
<td>Non Secure Email: <a href="mailto:SafeguardingAdults@thurrock.gov.uk">SafeguardingAdults@thurrock.gov.uk</a></td>
</tr>
<tr>
<td><strong>By safe haven Fax to:</strong> 01375 652760</td>
</tr>
<tr>
<td><strong>Making a referral/enquiry by telephone:</strong></td>
</tr>
<tr>
<td><strong>Community Solutions Team:</strong> 01375 652868</td>
</tr>
<tr>
<td><strong>Out of hours:</strong> 01375 372468 (Fax 01375 397080)</td>
</tr>
</tbody>
</table>
APPENDIX 2: SETSAF FORMS & GUIDANCE NOTES

To view a copy of the most up to date versions of the SET SAF forms and guidance notes for the completion of the forms please go to:
http://www.essexsab.org.uk/guidelines.htm

GUIDANCE NOTES FOR COMPLETING SET SAF1 (Safeguarding Adults Concern) FORM

Where safeguard concerns have been identified at stage one & stage two there must be an ongoing and documented RISK MANAGEMENT PLAN or the DASH RISK PLAN ( If required) - http://www.essexsab.org.uk/guidelines.htm

Introduction
The adult alert form (SET SAF 1) can be used by anyone to begin the adult safeguarding process.

The form should be used to record any specific concerns or incidents that relate directly to the care or welfare of an adult.

The form must be used whenever there are concerns that may identify possible abuse against an individual. The form should only be completed in respect of the alleged victim.

It is not to be used to outline generalised non specific concerns that would normally be addressed through social or care work process and involvement.

Details of the referral must always be recorded accurately and without delay. However Completion of SET SAF 1 must not delay immediate action being taken where necessary to ensure the safety of the vulnerable adult and the preservation of evidence if it is suspected that a crime has been committed.

Section 1 – Person you are concerned about
This section is for you to tell us who you are concerned about, it is important to complete as much identification information as possible, as this will help in ensuring that the correct person is identified from the information provided.

Section 2- Current situation and details of the incident/concern(s) being raised
This section of the form is critical to identify if the person or other people remain at risk. In this section it is important to state the actual risk, not unspecified vulnerability i.e. this person could be at risk if someone wanted to take money from them etc – the risk stated must relate directly to the specific concern that has instigated the completion of the SET SAF 1 – for example where it is alleged that someone has been assaulted by a staff member who is still in contact with the service user(s) then this would need to be highlighted as a current risk.
Details of the concern
This section is for telling us the main reason for the SET SAF 1 and needs to be a factual account or recording of the incident or event. It is important here to specify fact not opinion and will include observations stated by direct witnesses, the alleged victim, the location, time, date and anyone who was involved – including the identification of witnesses who may have been present in the area of the incident. This can be continued on a separate sheet, but please try to summarise as much as possible to present a clear pen picture of the incident, which may be read by someone who has no knowledge of the alleged victim or the service (if applicable).

Accurate description of injury
Use this section to accurately describe any injuries noted e.g. yellowing 3cm bruise to underside of left upper arm etc.

Body Chart Completion
Where appropriate, please include a body chart or forward as soon as possible. (body charts can be found on page 81)

Doctor informed
Please use these boxes to identify whether or not these actions have been taken.

Actions taken to safeguard the individuals
Please state here actions you have taken to reduce the risk of further incidents, these may include the removal of individual or alleged perpetrator from contact with each other or other parties, contacting other agencies – Police, GPs etc.

Are any other professionals involved in this alert?
Identify which other people (professionals and others) have been made aware of the concern or incident(s), please list names, roles and any reference number.

Name and Police Station for Investigating Officer:
Please obtain the name of the investigating officer, their police station and the Crime Reference Number which is obtained from the police when reporting a crime.

Section 3: Relative/Name of Main Carer
The relative/main carer section should include the person closest to the individual who may need to be contacted about the concerns (unless this person is identified as being part of the concern – if so please identify the person in section 4 of the SET SAF 1).

Section 4- Details of alleged perpetrator
This section is for identifying a person or persons who it is believed has contributed specifically to the incident or concern mentioned the alert relates to. It is important that any person named is as a direct consequence of the specific allegation and identification by the alleged victim or direct witness. It is not for speculation – please complete as much as is known – if this is single name i.e. “John” then please use this, if the person is not known, then please state this. In any incidents where the alleged abuser is a member of staff or resides with the alleged victim, please ensure this information is provided.
Section 5 – Telling us who you are
This section is for the person raising the concern to identify themselves. This part of the form should identify who this person is, and contact information so that further information can be obtained if required.

In the event that the person does not wish to be identified for reasons of anonymity, while reasonable efforts should be made to encourage the person to give contact information as this may assist in the safeguarding processes, if the answer is still no, then please state this in this section together with a reason if known.
GUIDANCE NOTES FOR THE COMPLETION OF SET SAF2 FORM

Where safeguard concerns have been identified at stage one & stage two there must be an ongoing and documented RISK MANAGEMENT PLAN or the DASH RISK PLAN (if required) - [http://www.essexsab.org.uk/guidelines.htm](http://www.essexsab.org.uk/guidelines.htm)

**Record of Process**

The SET SAF 2 acts as a checklist for the process followed to gather more information should the concern not be resolved or addressed after the receipt of the SET SAF 1. Where additional information is gathered in order to make a decision that the concern is not or no longer safeguarding this should also be recorded on the Set SAF 2.

It is important to gain the service users views, where possible, to understand their desired outcomes of the investigation. If these views are not sought the reasons why should be recorded.

The document should be used as a record of the preliminary information collected and requested through the initial investigation.

The form needs to be completed fully and to include the names of all individuals/professionals/agencies from which feedback or reports have been requested and record all visits made to collect information.

The form is also used to highlight additional information received since the original referral, and also to record any safeguarding strategies and outcomes agreed at this point.

It is important to remember that this form serves as a record of all information gathering activity from receipt of SET SAF 1 and may also include additional information gathered as a result of, or after, a safeguarding meeting.

The evaluation of information gathered on the SET SAF 2 during this process will help to establish the direction the process needs to follow.

For more information of Information Gathering please refer to Section 5.6 of the SET Adult Safeguarding Guidelines.
APPENDIX 2: SETSAF GUIDANCE NOTES

GUIDANCE NOTES FOR COMPLETION OF SET SAF 3 – MEETING RECORD

Please also review STAGE 3 section within the body of the SET Guidelines with further guidance about roles and responsibilities.

Where information gathered through the SET SAF 1 & 2 forms dictates that a formal safeguards meeting is required, the SET SAF 3 should be used as the standard format to record the meeting, list of attendees, summaries of the original concern and discussions held. The minutes are not verbatim.

The outcomes of the meeting and actions should also be fully recorded on the SET SAF 3 to include the names of people who will have responsibility for these actions/tasks, alongside clear and realistic timescales.

If action needs to be passed to an agency not present, the case co-ordinator must ensure this takes place.

At the meeting a coordinator for the action plan will need to be identified and noted, this person will also act as a central point of contact for information gathering.

The SET SAF 3 actions should be circulated to all who attend within 5 working days. The draft minutes should be shared with professional parties in attendance to check the factual accuracy of their information before circulation to the wider group. This is to ensure that information about conditions, points of law, etc are factually correct.

The SET SAF 3 minutes should be circulated to all who attend within 10 working days. Any questions or clarity about the content of the form must be made to the Chair within 5 working days of receipt. Only the Chair can agree to any changes to the content of the form.

Pending circulation of the draft meeting notes individuals should record and initiate their own actions.

The adult safeguarding meeting is confidential and minutes can only be distributed to those agency members attending or invited to attend the meeting or other designated managers of the agencies whose names shall appear on the distribution list on the front of the SET SAF 3.

Please consider implications of sharing the minutes with the victim or other parties if there are concerns that sharing them could increase the risk.

(The SET SAF 2 and 3 should be kept in relevant files and available for audit purposes as required and are not required as information for the provider, Essex Police or CQC unless those parties were in attendance or invited to the meeting).
APPENDIX 2: SET SAF GUIDANCE NOTES

GUIDANCE NOTES FOR THE COMPLETION OF SET SAF 4 – CASE MONITORING AND CLOSURE FORM

This form has been designed to track the progress of a case and its eventual closure.

Summary of Original Concern/Incident(s)
This section should be used to briefly summarise the original concerns that triggered the case.

Actions Taken in Response to Concern
This section should be used to record any significant events that occur for example meetings, moves, arrests inspections etc. Where necessary cross reference to other documents (for example a SETSAF 3) to avoid replication.

Reasons for Case Closure
The form must clearly state the reasons for the closure and offer a summary of evidence as to how and why this decision has been taken; the form will need to be countersigned by the responsible team manager.

On completion:
When the form has been completed and a copy retained for team/file use, please send a copy of the form to:

<table>
<thead>
<tr>
<th>Essex</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Adult Safeguards Unit</td>
</tr>
<tr>
<td>Email: <a href="mailto:adult.safegardsunit@essex.gov.uk">adult.safegardsunit@essex.gov.uk</a></td>
</tr>
<tr>
<td>Secure email Only: <a href="mailto:safeguardingessex@essex.gcsx.gov.uk">safeguardingessex@essex.gcsx.gov.uk</a></td>
</tr>
</tbody>
</table>

No Secure/ECC email address: SOVA.referrals@essex.gov.uk

If sending via non secure/ECC email address please password the document and inform the adult safeguards unit on a follow up email.

Fax No: 01245 550355 – For the attention of Adult Safeguards Unit

<table>
<thead>
<tr>
<th>Thurrock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email: <a href="mailto:SafeguardingAdults@thurrock.gov.uk">SafeguardingAdults@thurrock.gov.uk</a></td>
</tr>
<tr>
<td>Fax No: 01375652760</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Southend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable at this time</td>
</tr>
</tbody>
</table>
GUIDANCE NOTES FOR THE COMPLETION OF RISK ASSESSMENT AND RISK MANAGEMENT PLAN

Risks must be identified, in partnership with the vulnerable person involved in the safeguarding procedures where they have capacity, or with an appropriate person working in “best interests”.

The following flow chart identifies the process to follow in completing a risk assessment which is initiated during the information gathering process, continued and reviewed until closure or transfer.

CONCERN/INCIDENT REPORTED
SET SAF 1

RISK ASSESSMENT INITIATED

Is/was the relationship between the victim/alleged abuser any of the following?
Mother/Father
Grandparent/Great Grandparent
Children
Grandchildren/Great Grandchildren
Spouse/partner
In-laws or equivalent
Step-family

Yes
Complete SET SAF Risk or DASH risk assessment if a familial relationship

No
Complete risk assessment check list SET SAF

Risk Management Plan completed and reviewed at all stages of the process including closure and kept on service user file

If very high risk is identified consider referral to MARAC* and discuss with manager re police involvement if not already involved.

Yes answers identified on scorecards

* Multi Agency Risk Assessment Conference
APPENDIX 3: SET SAF 3 – Letter Templates

Letter Examples for SET SAF 3

Easy Read Letter

Invitee

CONFIDENTIAL

Dear

Invitation to attend your Safeguarding Meeting

We are holding a Safeguarding Meeting on ………….. (date and time) at……………… …(place)

To discuss the recent safeguarding issues relating to (safeguarding allegation)………………………..................................

At this meeting we will look at the risks involved and how we can all manage these with what we call a Safety Plan if you need one.

Before the meeting …………………(name of) your care coordinator/social worker will meet with you to discuss what will be involved and what information will be shared with others there. You can also request an advocate – this is someone who will talk to you about what is important to you and will support you in making these views known at the meeting. These will be…………… (list of other invited attendees and titles).

At the meeting you will be able to put your views forward and if you would like to have a friend, relative or advocate there with you please let …………..(name of care co-ordinator etc.) know.

When you arrive at ……………….. please contact …………………

Yours sincerely,

Insert name
Insert title
APPENDIX 3: SET SAF 3 – Letter Templates

Letter for Professionals

Invitee

CONFIDENTIAL

Invitation to a Safeguarding Meeting

You are invited to a Safeguarding Vulnerable Adults Meeting in respect of: ……………………………….(insert name of vulnerable person)

Reason for meeting: Safeguarding Allegation

A Safeguarding Meeting has been convened under SET (Southend, Essex & Thurrock) Safeguarding Vulnerable Adults procedures, regarding the above person, to be held on ________ 2014 at ________.

Please report to …………………...(insert/delete as required)

It is hoped that you or your representative will be able to attend on this date. Please come prepared to contribute information and assist the meeting in participating in discussion. If you are requested to provide an internal/clinical investigation, it is good practice to provide a written report in support of your oral contribution to the Safeguarding Meeting in advance. If you do not have your own report template, please find enclosed a suggested format that has been agreed by SET.

The report should be sent to the …………………Team or e-mailed password protected/securely to the following e-mail address: ………………………. The report should be received at least 48 hours/two working days prior to the Safeguarding Meeting.

If you are unable to attend but have relevant information and wish to make any comments it is essential you submit a written report to be received at least 48 hours/two working days prior to the Safeguarding Meeting.

Attached is a list of people who have been invited to the Safeguarding Meeting. Usually all of these, including service user, will receive a copy of the minutes of the Safeguarding Meeting.

Also Invited

<table>
<thead>
<tr>
<th>name</th>
<th>title/role</th>
</tr>
</thead>
<tbody>
<tr>
<td>name</td>
<td>title/role</td>
</tr>
</tbody>
</table>

Yours Sincerely
Service User Invite

Invitee

CONFIDENTIAL

Dear

Re:

Reason for Safeguarding Meeting: To Review whether there is a Risk of Significant Harm & whether a Safety Plan is required.

This letter is to invite you to attend a Safeguarding Vulnerable Adults Meeting on ________ at ________.

Please report to .....................................(insert location)

The purpose of this Safeguarding Meeting is to consider whether there is continued risk of significant harm which requires a Vulnerable Adults Safeguarding Plan. Prior to the meeting the care co-ordinator/social worker will share any necessary reports with you and explain the format of the meeting. You will have the opportunity, at the meeting, to express and discuss your opinions, therefore you may wish to bring a friend, relative or advocate to support you. Before attending please can you please ensure that you inform the care manger of their name (and role).

The meeting will be used to distribute and fully consider all the information and make appropriate recommendations. If the meeting decides there is continued risk of significant harm, then an updated Vulnerable Adults Safeguarding Plan will be made. If the meeting decides there is no longer risk of significant harm, then a plan may be agreed to ensure that you continue to receive the necessary services to meet those needs.

Enclosed is a list of the people who have been invited to attend. Not all the people on the list will necessarily come to the meeting. Should you have any queries please contact me at the above address/telephone number. I look forward to meeting you.

Also Invited

<table>
<thead>
<tr>
<th>name</th>
<th>title/role</th>
</tr>
</thead>
<tbody>
<tr>
<td>name</td>
<td>title/role</td>
</tr>
</tbody>
</table>

Yours Sincerely
APPENDIX 4: BODY CHARTS

The chart overleaf is a useful and simple way of recording injuries as an aid to later diagnosis. It is better to record what is actually observed than to speculate on the cause of the injuries at this stage.

If the body chart is to serve as a monitoring tool for minor injuries observed over a period of weeks (or even months), **a new body chart should be used on each occasion.** It is therefore very important to be consistent in the method of recording injuries so that comparisons can be made with earlier charts. **Where several different staff may be completing the monitoring forms, managers should ensure they understand what is required of them.**

The following points should be covered:

- describe any marks, swelling, lacerations or other injuries carefully (cuts, bruises, scratches)
- describe the colour (brown/yellow/blue), size and shape of any bruises and indicate their location on the body chart; also describe any pattern if there are several bruises close together
- briefly list any relevant circumstances witnessed, such as anger or aggression by vulnerable adult or by anyone in contact with the vulnerable adult
- also record any explanations of injuries given immediately by the vulnerable adult and any other witnesses
- ensure that for each chart completed the date and time of examination are clearly entered along with the name of the person completing the chart.
Please describe any marks you make on the chart e.g. cut, bite, bruise (and whether yellow or blue etc.).

Date and time: ________________________________
Completed by: ________________________________

Body chart - male
Please describe any marks you make on the chart e.g. cut, bite, bruise (and whether yellow or blue etc.)

Completed by: ______________________________

Date and time: ______________________________
APPENDIX 5: MEDICATION MANAGEMENT CONCERNS

South Essex Guidance for when Medication Management Concern is identified in Care Homes & Care Agencies.

- Medication error/mistake
- No harm caused
- Previous concerns regarding the worker but nothing serious
- Internally identified ‘gaps’ in training supervision and auditing

- Medication error
- Minimal harm to one or more people
- Previous concerns but nothing catastrophic
- Insufficient prevention measures in place

- Medication error causing serious/significant harm to person leading to the need for medical treatment
- Previous concerns identified ongoing ineffectiveness, repeated bad practice
- Covert approaches to errors
- Insufficient prevention measures such as training, supervision & auditing
- Statutory CQC Notification

- One medication error causing catastrophic harm to one person/hospitalisation/irreparable damage/death
- Previously identified significant concerns
- Insufficient prevention measures
- Statutory CQC Notification

**LEVEL 1**
Providers
Informal
Procedures

**LEVEL 2**
Providers
Formal Complaints
Procedures

**LEVEL 3**
SET SAF 1

IF UNSURE, SEEK ADVICE

SET Safeguarding Adults Guidelines – Version 3 – April 14
APPENDIX 5: MEDICATION MANAGEMENT CONCERNS

This is guidance to try to help care home and agency managers decide what route of investigation to follow and whether a medication error could be a safeguarding issue.

It should be used in conjunction with local and national policy, CQC requirements and professional responsibilities.

For those adults that need to take medication to maintain their health and wellbeing it is essential to ensure that the person has the right level of medication and has access to medication when necessary.

It is also important that medication is not given without consent. If a person is unable to consent then the evidence of this and a clear best interest decision should be in place. These should be reflected in the care plan and the care plan should be followed.

CQC Outcome 9 (Management of Medicines) of the ‘Essential Standards of Quality and Safety’ should be followed and from 1 October 2010, the Care Quality Commission (CQC) under the Health and Social Care Act 2008 must be notified about specific incidents. The law requires these notifications to be submitted within certain timescales – further guidance is available on what should be reported, how and in what timescales via the CQC guidance on Statutory Notifications.

It is necessary to accept that medication errors do occur and that they can occur for a variety of reasons. However, not giving the appropriate medication at the right time could be considered neglect. Not all medication errors cause harm to the person receiving the medication. However, there are certain occasions when medication errors can lead to serious harm both physically and emotionally to the vulnerable adult.

All medication errors should be investigated so that learning can be used to improve practice and reduce the number and severity of future errors. The guidance is to try to help you decide which level of investigation and action should take place.
APPENDIX 6: SELF-NEGLECT GUIDANCE

SAFEGUARDING ALERT RAISED RE SELF NEGLECT OR HIGH RISK

Assessment visit to ascertain situation/risk and determine capacity

Does the Person have Capacity?

YES

Identify worker from SG team /operational team to lead or support

Convene a multi disciplinary meeting with relevant agencies
Must include
Safeguarding
May include – as appropriate
Service user
Mental Health
Community Health (DN/GP)
Adult Social Care
Housing
Advocates
Police
Legal
Others as required

N

Use principles of Mental Capacity Act and Guidance
IMCA/Advocate
Best Interest Meeting
Risk Assessment/ Management Plan
SAFEGUARDING ACTION TAKEN AS APPROPRIATE TO ENSURE SAFETY

RISK ASSESSMENT AND RISK MANAGEMENT PLAN

Shared with Individual – All efforts to be made to engage

Additional supporting assessments

SAFEGUARDING ACTION TAKEN AS APPROPRIATE TO ENSURE SAFETY

Most relevant team/worker

Complete a self assessment and support plan.
Provide services as appropriate.

Engagement

Non Engagement

Advise individual of risks identified in writing.
Contract outlining the ownership of the risk to be formulated and shared with the individual.
All involved agencies to be advised.
Devise monitoring arrangements.
APPENDIX 6: SELF-NEGLECT GUIDANCE

APPENDIX 6: SELF-NEGLECT GUIDANCE

Situations, following assessment, where it is recognised that there is a high risk of self neglect or other high risk situations, which do not fall within the strict remit of abuse, should be raised with the safeguarding team.

The flow chart on the previous page identifies the stages which should be followed to ensure that all of these situations are examined to determine the level of risk and also whether the person subjected to this risk, either through their own behaviour or self neglect has the capacity to understand the implications of their actions.

If it is established that the person involved does not have the capacity to understand the risks and their implications then this should proceed through a safeguarding route, following the process outlined in the Southend, Essex and Thurrock Guidelines, and in line with the Mental Capacity Act and Guidance.

Where the person is deemed to have the capacity to understand the implications of their actions or in actions then every effort should be made to encourage them to engage with support.

A multi-disciplinary meeting should be convened to discuss all of the options for solutions, considered alongside all relevant professional assessments or reports to develop the risk assessment and risk management plan. The individual should again be encouraged to engage with the most appropriate services to minimise the risks identified.

If the individual does agree to engage this can then be referred to the relevant team to support and a self assessment and support plan completed with appropriate services provided.

Where the individual continues not to engage to minimise the risks these should be explained with them in person if possible but also in writing, together with a contract outlining their ownership of the risks identified.

This may or may not be signed by the individual, however all involved agencies should be aware of the risk assessment and its ownership. Arrangements should also be made to monitor the situation by the most appropriate agency, and overseen by the adult safeguarding team.

This will evidence that the Local Authority have taken every possible step to try to resolve the situation, but it is acknowledged that some people chose to live and continue to live in risky situations.
APPENDIX 7: RESOLUTION OF PROFESSIONAL DISAGREEMENTS

Problem resolution is an integral part of professional co-operation and joint working to safeguard vulnerable adults. Concern or disagreement may arise over another professional’s decisions, actions or lack of actions, in relation to a referral, an assessment or an enquiry.

It is important to:

- Avoid professional disputes that put the adult(s) at risk or obscure the focus of the vulnerable adult
- Resolve difficulties (within and) between agencies quickly and openly
- Identify problem areas in working together where there is a lack of clarity and to promote resolution via amendment to protocols and procedures.

The safety of vulnerable adult(s) are the paramount considerations in any professional disagreement and any unresolved issues should be escalated with due consideration to the risks that might exist.

For disputes within agencies, in house procedures should be followed. This process relates to the resolution of differences between agencies.

PROFESSIONAL DISAGREEMENTS – STAGE 1

The aim should be to resolve difficulties at practitioner/fieldworker level between agencies.

Initial attempts should be taken to resolve the problem within a maximum of five working days for stages 1 and 2 or earlier if the adult is at risk. This should normally be between the people who disagree, unless the adult is at immediate risk.

It should be recognised that differences in status and/or experience may affect the confidence of some workers to pursue this unsupported.

PROFESSIONAL DISAGREEMENTS – ESCALATION - STAGE 2

If unresolved, the problem should be referred to the worker’s own line manager who will discuss with their opposite number in the other agency.

Most day to day inter-agency differences of opinion will require a local authority Adult Social Care team manager to liaise with their (first line manager) equivalent in the relevant agencies, e.g.:

- A police Detective Sergeant
- A named health professional
- Care provider manager
APPENDIX 7: RESOLUTION OF PROFESSIONAL DISAGREEMENTS

PROFESSIONAL DISAGREEMENTS – ESCALATION - STAGE 3

If agreement cannot be reached following discussions between the above first line managers within a maximum of a further working week or a timescale that protects the vulnerable adult from harm (whichever is less), the issue must be referred without delay through the line management to the equivalent of service manager, Detective Inspector or other designated senior professional.

The professionals involved in this conflict resolution process must contemporaneously record each intra and inter-agency discussion they have, approve and date the record and place a copy on the adults file together with any other written communications and information.

If the problem remains unresolved, the line manager will refer ‘up the line’. Any verbal report should be followed up in writing, showing the nature of the dispute and what attempts have been made to resolve this.

PROFESSIONAL DISAGREEMENTS – ESCALATION – STAGE 4

If professional differences remain unresolved, the matter must be referred to the relevant senior manager for each agency involved, with a copy being sent to the Chair of the appropriate area safeguarding board. This should include forwarding a written account of the dispute and what attempts have been made to resolve this.

In the unlikely event that the issue is not resolved by the steps described, consideration will be given to referring the matter to the Chair of the appropriate area Safeguarding Board who will offer mediation/or refer to the appropriate area Safeguarding Board sub-committee as soon as possible bearing in mind the impact on the vulnerable adult(s). A clear record should be kept at all stages, by all parties. In particular this must include written confirmation between the parties about an agreed outcome of the disagreement and how any outstanding issues will be pursued.

When the issue is resolved, any general issues should be identified and referred to the agency’s representative on the appropriate area’s safeguarding board for consideration by the relevant area’s safeguarding boards sub-group to inform future learning.

At any stage in the process, it may be appropriate to seek expert advice to ensure resolution is informed by evidence based practice.

It may also be useful for individuals to debrief following some disputes in order to promote continuing good working relationships.

DISSENT ABOUT IMPLEMENTATION OF THE ADULT SAFEGUARDING PLAN

Concern or disagreement may arise over another professional’s decisions, actions or lack of actions in the implementation of the adult safeguarding plan.

The line managers of the professionals involved should first address these concerns.
APPENDIX 7: RESOLUTION OF PROFESSIONAL DISAGREEMENTS

If agreement cannot be reached following discussions between the above ‘first line’ managers, the issue must be referred without delay through the line management to the equivalent of service manager/ detective inspector or other designated professional.

WHERE PROFESSIONAL DIFFERENCES REMAIN

If professional disagreements remain unresolved, the matter must be referred to the heads of service for each agency involved.

In the event that the issue is not resolved by the steps described above and/or the discussions raise significant policy issues, it may be helpful to convene a relevant area safeguarding board sub-committee which has the brief to consider policy and practice or serious cases.
RESOLUTION OF PROFESSIONAL DISAGREEMENT - Flowchart

Stage 1
Attempts to resolve problem by those who disagree

Stage 2
Workers own line manager or Safeguarding adult lead discusses with their opposite number in the other agency

Stage 3
If concerns continue refer through line management structure to service manager Detective Inspector or other designated person.
Timescale with a maximum of a further working week or earlier if the vulnerable adult is at risk

Stage 4 (a)
If professional difference remains unresolved refer up to relevant senior manager in the organisation in writing with a copy to the appropriate area Safeguarding Board chair

Stage 4 (b)
If unresolved refer to the appropriate area Safeguarding Board chair who will determine how this will be resolved. This could be:
- Resolution
- Mediation
- Referral to Board Sub Group
- Expert Advice

Feedback to professionals

All stages actions/decisions must be recorded in writing and shared with relevant personnel