County Durham
SAFEGUARDING ADULTS
INTER-AGENCY PARTNERSHIP

Workbook 2

Safeguarding Adults Training

Managing the Alert

Working with The Safe Durham Partnership *Altogether safer*

Safeguarding Adults Managing an Alert

Welcome to the course. We hope you enjoy the day and that it is helpful to you in the work that you undertake.

During the day you will receive a number of handouts with useful information, copies of the PowerPoint slides and pointers to where you can access further information on areas of interest. These are yours to take away at the end of the session.

The course will be interactive, with plenty of opportunity for you to contribute and ask questions. You will also be able to network with staff from other teams and organisations and share information and ideas with them.

Course Aim

To provide participants with an increased awareness and understanding of Durham's safeguarding adults' procedure and, in particular, the role and responsibilities of the person receiving an alert.

Course Objectives

By the end of the session staff will

- Know what action to take if an allegation of abuse is reported to them by a member of staff
- Understand what they have to consider when deciding whether to make a safeguarding referral, including the use of the risk support tool
- Understand safeguarding adults' processes and procedures and their own responsibilities within these, including supporting the adult at risk and staff involved
- Understand the importance of recording and documenting all information.
- Have increased knowledge of the parallel processes such as referral to ISA, HR and disciplinary processes.
- Understand the importance of considering ways to keep the adult at risk safe and prevent abuse occurring.

Session Outline

The session will start at 9.30am prompt and will include.

- Introductions, aims and objectives and ground rules.
- Safeguarding Crossword.
- Barriers to staff reporting alerts and how to overcome these.
- Good practice in preventing abuse
- Making the decision to make a safeguarding referral.
- Case study - using the risk support tool.
- Referring to Social Care Direct
- Capacity, consent and confidentiality
- The safeguarding process and procedures.
- Parallel considerations during the safeguarding process.

Key Definitions

Adult at Risk (formerly referred to as a vulnerable adult)

An 'adult at risk' is someone aged eighteen or over, who is or may be eligible for community care services and whose independence and well-being would be at risk if they did not receive appropriate health and social care support.

This definition also specifically includes those people whose need in relation to safeguarding is for access to mainstream services such as the police.

The person may have a physical impairment, a sensory loss or learning disability – perhaps present from birth or due to advancing age, chronic illness or injury. They might self-harm, be dependent upon or misuse substances such as alcohol or drugs, or experience physical or mental ill-health.

An adult at risk isn't necessarily a service user. They may be a carer, a family member or friend who provides personal assistance and care to another on an unpaid basis.

For the purpose of the Durham Interagency Procedures the adult at risk needs to be either a permanent or temporary resident of Durham County.

Adult 'abuse' and 'neglect'

Abuse –'the misuse of power by one person over another – has a large impact on a person's independence. Neglect can prevent a person who is dependent on others for their basic needs exercising choice and control over the fundamental aspects of their life and can cause humiliation and loss of dignity.' (Safeguarding Adults', ADSS 2005)

- Abuse is a violation of an individual's human and civil rights.
- 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.
- It may occur when a person is persuaded to enter into a financial or sexual transaction to which he or she does not consent or cannot consent.
- Abuse may be deliberate, or unintentional.

And

- Abuse may cause harm temporarily over a period of time.

The Durham Multi-Agency Safeguarding Adults Board has agreed to adopt a clear policy of **zero-tolerance of abuse** within each of its component organisations.

- The Board recognises that it is every person's right to live their life free form violence and abuse.

- It takes seriously its duty placed on public agencies under human rights legislation to intervene proportionately to protect the rights of citizens.

Perpetrator of abuse

Anyone can be a perpetrator of abuse. Abuse can occur in any relationship, especially where there is an expectation of trust and the abuser is well known to the person being abused.

Abuse can occur in situations where there is an imbalance of power or control and the abuser misuses that power either intentionally or unintentionally, or for their own benefit or gain.

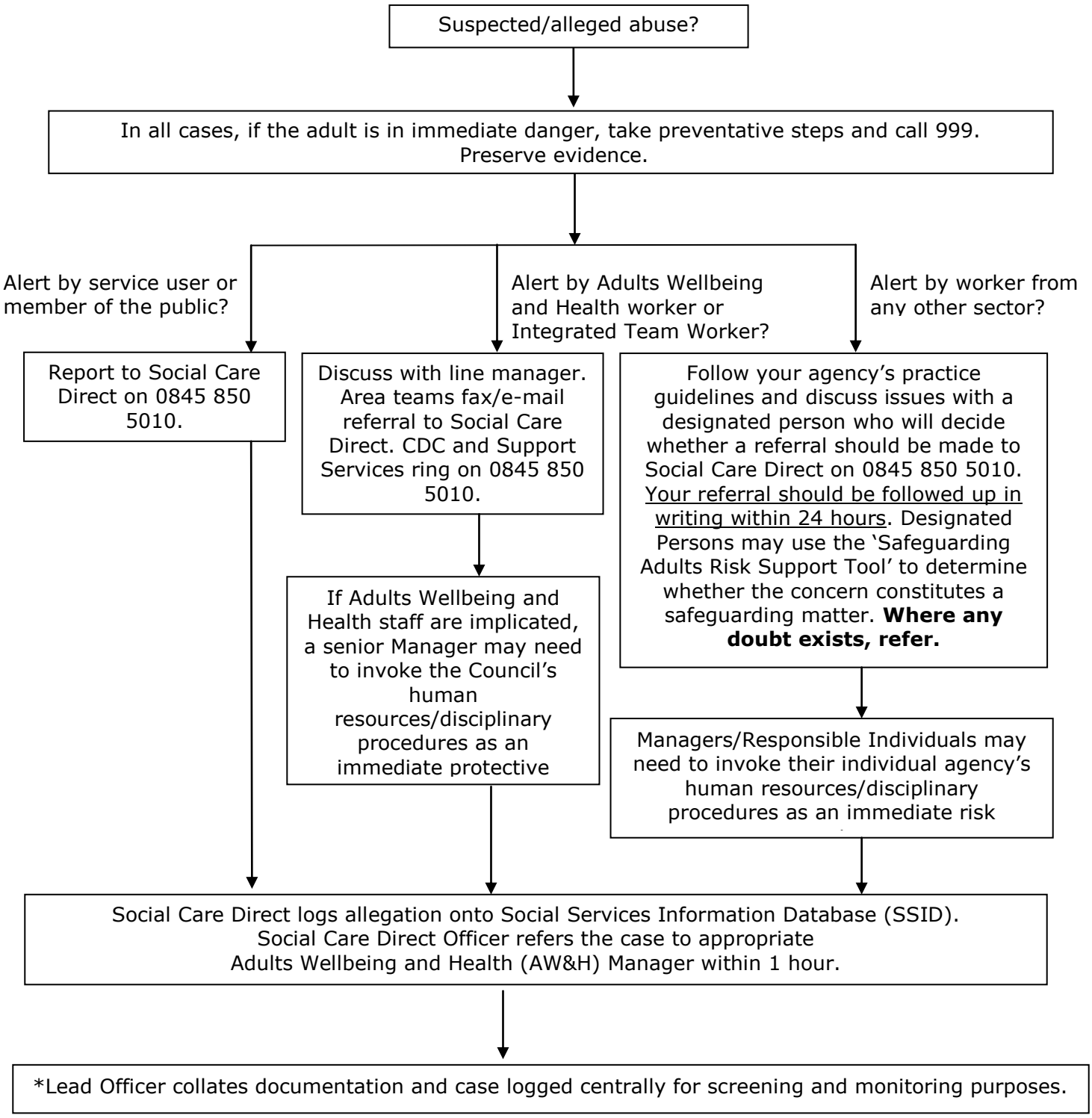
An individual, a group, or an organisation may perpetrate abuse. An abuser may be a relative, a friend or neighbour, a paid or voluntary care worker or health care or social care professional, a non-carer or a stranger.

Safeguarding

All the work which enables an adult who is or may be eligible for community care services to retain independence, well-being and choice, and to access their human right to live a life that is free from abuse and neglect.

(Taken from County Durham Interagency Policies and Procedures - January 2009)

Flowchart 1: The alert and referral to Social Care Direct



*The Lead Officer will be an Adults Wellbeing and Health Manager or appropriate senior social care or health professional
P&PS - Policy and Procedures
SSID – Social Services Information Database

Remember to observe human resources policies and procedures in parallel with any **safeguarding action**

Safeguarding Adults – a step by step summary of the procedure

STEP	TIMESCALES	**ACTION**	BY WHOM	**REFERENCE**
1. Identifying the concern	Immediately	A concern may centre around a single or repeated acts, which constitute abuse or neglect. Upon suspicion or disclosure that abuse or neglect is occurring/has occurred, concerns should be shared through the appropriate channels as described below. For staff employed by any of the safeguarding partners, the responsibility to share such concerns is part of their 'duty of care'. Where an adult is in immediate danger, action should also be taken to protect the safety of that person, e.g. by calling for emergency medical assistance. Immediate protective action should not incur irresponsible risk for the person identifying the concern.	Anyone in contact with or having knowledge of an adult(s) 'at risk'.	Policy and Statement of Commitment (red): Aims of the policy Working with adults at risk Procedural Framework (green): Suspected or alleged abuse or neglect in services provided by the Health Trusts Supplementary Guidance (blue): Legal and ethical context • Key legislation and Confidentiality • Definitions and categories of abuse (all sub-parts) Roles and responsibilities • Adults Wellbeing and Health key individual and team roles – Alerter

STEP	TIMESCALES	**ACTION**	**BY WHOM**	**REFERENCE**
2. Alert and referral to Social Care Direct	Immediately – the main objective should always be to act in the adult's 'best interests' and prevent further harm.	Service users, carers and members of the public (including adults at risk) should report suspicions/allegations of abuse to Social Care Direct on 0845 8505010. Employees, students on placement and voluntary workers should report concerns to the designated person or postholder (usually a Manager) identified within each agency's own safeguarding guidelines. Where another worker is implicated whistle blowing or 'speaking out' procedures should be used to alert an appropriate person to the situation. Where the designated person may be implicated in the abusive practice, an alert should be made to Social Care Direct, and for registered services the CQC. A written record must be made as soon as practicably possible. N.B. Where a Social Worker or other lead practitioner employed by Adults Wellbeing and Health receives an alert or is party to a disclosure, then he or she must e-mail or fax the details to Social Care Direct and immediately report the matter to his or her Manager. In-house provided services ring Social Care Direct in the usual way. Where a criminal offence is suspected, the Police must also be contacted.	Anyone who suspects or knows that abuse has occurred and needs to report this so that safeguarding action can be taken.	Policy and Statement of Commitment (red): Aims of the policy Working with adults at risk Procedural Framework (green): Alert Suspected or alleged abuse or neglect in services provided by the Health Trusts Safeguarding Adults Risk Support Tool Supplementary Guidance (blue): Legal and ethical context • Key legislation and guidance Confidentiality • Whistle blowing or 'Speaking out' Roles and responsibilities • Adults Wellbeing and Health • Key individual and team roles – Alerter • Designated post holders • The Police • The Care Quality Commission

STEP	TIMESCALES	**ACTION**	**BY WHOM**	**REFERENCE**
3. The designated person receives an alert and makes a referral to Social Care Direct	Within 1 working day of the alert being received.	Upon receipt of an alert via safeguarding or 'speaking out' procedures, the designated postholder must review the information provided and make a decision about whether the reported concerns constitute abuse. The Safeguarding Adults Risk Support Tool might be useful here. Where the possibility of abuse cannot be ruled out, a referral must be made to Social Care Direct on 0845 8505010, and followed up with a written report including precise factual details of the allegation. In the case of any uncertainty about how to proceed, a formal pre-referral consultation process is available from the Safeguarding Adults and Practice Development Team. If a crime is suspected, no attempts should be made to question the adult at risk or any other witnesses. This will be done as part of a formal Police investigation. Provider services should refer to their organisation's internal human resources/suspension/staff disciplinary procedures to protect the interests of the adult(s) at risk and any staff members concerned. Contact should also be made with the regulatory bodies. Allegations against staff employed by the statutory safeguarding agencies/adult placement carers must be dealt with in accordance with the procedure described in this framework. Managers within Adults Wellbeing and Health should seek advice from an appropriate senior Manager about taking steps to invoke the Council's disciplinary procedures. Implicated staff/volunteers who also have contact with children through their work should be referred to the Council's nominated 'Senior Manager', or in the case of familial contact, Children's Services.	The designated postholder/ person within any of the safeguarding partner organisations, or any care service to whom alerts must be reported. Alternatively a Social Worker or practitioner to whom the adult is already known.	Policy and Statement of Commitment (red): Aims of the policy Working with adults at risk Procedural Framework (green): Referral Safeguarding Adults Risk Support Tool Suspension, staff disciplinary procedures and support for implicated staff Allegations against Adults Wellbeing and Health employees Allegations against adult placement carers Allegations against employees of other statutory safeguarding agencies Allegations of adult abuse/neglect which implicate workers or adult placement carers who may also have access to children Supplementary Guidance (blue): Legal and ethical context • Key legislation and guidance • Confidentiality • Whistle blowing or 'Speaking out' Roles and responsibilities • Adults Wellbeing and Health • Key individual and team roles – Designated post holders • Social Care Direct • The Police • The CQC

STEP	TIMESCALES	ACTION	**BY WHOM**	**GUIDANCE REFERENCE**
4. Social Care Direct	Referral to be passed to Adults Wellbeing and Health Manager within 1 hour of receipt.	In response to any call regarding a safeguarding matter, the Social Care Direct Officer will: • gather and record as much information as possible about the alleged abuse; • check all available records to determine whether any parties are already known; • decide upon the most appropriate immediate response; and • enter the referral onto the Social Services Information Database (SSID). Where both the victim and the alleged perpetrator are 'adults at risk', a separate safeguarding referral for the latter is not required. A standard referral should instead be completed. The exception to this would occur when both adults are victims, and it is not possible to determine which is the primary perpetrator. Using an incorrect party coding will distort safeguarding performance data. In the majority of cases referrals will be allocated to an Adults Wellbeing and Health Manager for decision making, but where it is clear that the identified adult is not 'vulnerable' or exposed to critical or substantial risk, the referrer may need to be signposted to a more appropriate agency. It is the SCD Officer's responsibility to ensure that each safeguarding referral is sent to the appropriate Adults Wellbeing and Health Manager for decision making. N.B. Where a Social Worker or other lead practitioner employed by Adults Wellbeing and Health receives an alert or is party to a disclosure, then he or she must e-mail or fax the details to Social Care Direct and immediately report the matter to his or her Manager. **Alerters (whether professional or members of the public) should not be expected to make the same alert twice.**	Social Care Direct Officer/Social Care Direct Team Manager or Social Worker, other lead practitioner	Policy and Statement of Commitment (red): Aims of the policy Procedural Framework (green): Social Care Direct Recording referrals for alleged perpetrators who are 'adults at risk' Adults who are exposed to serious risk to life and limb whose circumstances are not readily recognisable as safeguarding concerns Templated documentation Supplementary Guidance (blue): Legal and ethical context • Key legislation and guidance • Confidentiality Roles and responsibilities • Adults Wellbeing and Health and Assessing Officer • Key individual and team roles – Social Care Direct

STEP	TIMESCALES	**ACTION**	**BY WHOM**	**REFERENCE**
5. Receiving the referral - decision making by the Adults Wellbeing and Health Manager	On the same day that the referral is received. The referrer must be advised of action to be taken within one working day of making contact with Social Care Direct.	The Adults Wellbeing and Health Manager (AWHM) must decide whether and how to invoke the safeguarding procedures. He or she must: • consider the referral information in its context; • consider the reliability/credibility of the information received; and • carry out an initial risk assessment. Decision making must take place in consultation with the identified adult at risk. Unless circumstances dictate otherwise, the adult's consent to take part in a safeguarding assessment is required. Issues of capacity must be taken into account. Referrers must be advised about how their concerns will be addressed by the end of the next working day. Decisions must be recorded on SSID. Advocacy/other support as required must be sourced for the adult at risk. The AWHM must ensure that the adult is kept safe throughout the safeguarding process and make contact where necessary with the Police, CQC, and the multi-agency risk management partners*. In the event of a death, the Coroner's Office must be informed and. Serious injury/accidents must be reported to the Council's Health and Safety and Staff Care Team, who will refer to the Health and Safety Executive if necessary. Where a child(ren) may be at risk, a referral made immediately to the Child Protection Team. The appropriate safeguarding partners should be invited to take part in a safeguarding strategy discussion/meeting or executive planning meeting as appropriate. A robust record must be kept of all discussions, risk assessments, decisions (to proceed or otherwise) and actions. SSID entries must be kept up-to-date. *For MAPPA call (0191) 3839083 For MARAC call (0191)3752072	An Adults Wellbeing and Health Manager	Policy and Statement of Commitment (red): Aims of the policy Procedural Framework (green): False allegations Decision Risk/protection Allegations of adult abuse/neglect which implicate workers or adult placement carers who may also have access to children Adults who are exposed to serious risk to life and limb whose circumstances are not readily recognisable as safeguarding concerns Templated documentation Supplementary Guidance (blue): Legal and ethical context • Key legislation and guidance • Confidentiality • MAPPA/PDP • Capacity and consent • Place of safety • Advocacy and support Roles and responsibilities • Adults Wellbeing and Health • Key individual and team roles – Social Care Direct and Adults Wellbeing and Health Manager

Group Work - Barriers to Raising an Alert

Barriers to raising an alert	**Remedies to barriers**

Group Work
Ways of Preventing Abuse

Recruitment and Selection	**Planning Care and Managing Risk**	**Process and procedure**	**Dignity in Care**	**Management and Commissioning**

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Risk Threshold Tool

Factors						Guidance
1. The vulnerability of the victim	Less vulnerable		More vulnerable			• Can the adult protect themselves, and do they have the communication skills to raise an alert? • Does the person lack mental capacity? • Is the person dependent on the alleged perpetrator?
2. Type and Seriousness of Abuse	**Low Risk**		**Moderate**	**High**	**Critical**	• Refer to the table overleaf, Types and Seriousness of Abuse. Look at the relevant categories of abuse and use your knowledge of the case, and your professional judgement, to gauge the seriousness of concern. • Incidents that might fall outside safeguarding procedures (column 1 & 2 overleaf) could potentially be better dealt with via staff training/supervision, care management and/or complaints procedures for instance. • Professional abuse can occur in relation to any of the categories listed left. **This tool does not replace professional judgement nor aim to set a rigid threshold for intervention. Note professional decision making reflects the fact that the type & seriousness of abuse may fall within the low risk threshold, other factors may make the issue more serious and therefore warrant progression via safeguarding procedures.**
Physical						
Sexual						
Psychological						
Financial						
Neglect						
Institutional						
Discriminatory						
3. Pattern of abuse	Isolated incident		Recent Abuse		Repeated abuse	Determine if the abuse is/was: • A one off incident? • A recent incident in an ongoing relationship? • A repeated abuse that has gone on for a length of time?
4. Impact of abuse on victim	Low impact				Seriously affected	• Impact of abuse does not necessarily correspond to the extent of the abuse • Sometimes serious acts can be withstood by an individual who has plenty of support, whereas even minor abuse can be devastating if perpetrated by someone who the person trusts or is the only source of support
5. Impact on others	No one else affected		Others indirectly affected		Others directly affected	Other people may be affected by the abuse of another adult. Determine if: • No-one else involved or witnessing the abuse? • Relatives or other residents/service users are distressed or affected by the abuse? • Other people are intimidated and/or their environment affected?
6. Intent of alleged perpetrator	Unintended				Deliberate/ Targeted	Determine if the abuse is/was: • Unintentional or ill informed? • Violent/serious unprofessional response to difficulties in caring? • Planned and deliberately malicious? ***The act/omission doesn't have to be intentional to meet safeguarding criteria**
7. Illegality of actions	Bad practice but not illegal		Criminal act		Serious criminal act	Seek advice if you are unsure if a crime has been committed. Try to determine: • Poor or bad practice (but not illegal)? • Whether it may be against the law? • If it is clearly a crime?
8. Risk of repeated abuse on victim		Unlikely to recur	Possible to recur	Likely to recur		Is the abuse: • Unlikely to happen again? • Less likely with significant changes, e.g. training, supervision, respite, support • Very likely even if changes are made and/or more support provided?
9. Risk of repeated abuse on others	Others not at risk		Possibly at risk	Others at risk	Others at serious risk	Are others (adults and/or children) at risk of being abused: • Very unlikely? • Less likely if significant changes are made? • This perpetrator/setting represents a threat to other vulnerable adults or children?

Adapted from 'Aims for Adult Protection, The investigator's Guide', Pavillion Publishing, 1989.

AWH7926 Adults, Wellbeing and Health, Marketing and Information Team, 2012

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Types Of Abuse And Seriousness	Examples of concerns that do not require formal safeguarding procedures and can be dealt with by other systems: e.g Complaints, Care/Risk Management, Disciplinary. It is likely that only concerns in the second column need to be reported to SCD - use professional judgement.		The examples below are likely to indicate the need for a referral for formal procedures. If you are in any doubt about whether a concern constitutes a safeguarding matter, refer to Social Care Direct on 0845 850 50 10. If there is any immediate danger to an individual evident, call 999 straight away.		
Level of Risk	**Minimal Risk**	**Low Risk**	**Moderate**	**High**	**Critical** Potential criminal matter – Police/Emergency Services contact necessary. Consider MAPPA, MARAC, Hate Crime
Physical	• Staff error causing no/little harm, e.g. friction mark on skin due to ill-fitting hoist sling • Minor events that still meet criteria for 'incident reporting' accidents **..... Medication .....** • Adult does not receive prescribed medication (missed/wrong dose) on one occasion - no harm occurs	• Isolated incident involving service on service user • Inexplicable marking found on one occasion • Minor event where users lack Capacity **..... Medication .....** • Recurring missed medication or administration errors that cause no harm	• Inexplicable marking or lesions, cuts or grip marks on a number of occasions • Accumulations of minor incidents **..... Medication .....** • Recurring missed medication or errors that affect more than one adult and/or result in harm • Potential serious consequences	• Inappropriate restraint • Withholding of food, drinks or aids to independence • Inexplicable fractures/injuries • Assault **..... Medication .....** • Deliberate maladministration of medications • Covert administration with out proper medical authorisation	• Grievous bodily harm/assault with a weapon leading to irreversible damage or death **..... Medication .....** • Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death
Sexual	• Isolated incident of teasing or low-level unwanted sexualised attention (verbal or touching) directed at one adult by another whether or not capacity exists	• Minimal Verbal sexualised teasing or banter	• Recurring sexualised touching or isolated/recurring masturbation without valid consent • Voyeurism without consent • Being subject to indecent exposure	• Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent • Being made to look at pornographic material against will/where valid consent cannot be given	• Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user • Sex without valid consent (rape)
Psychological	• Isolated incident where adult is spoken to in a rude or other inappropriate way – respect is undermined but no or little distress caused	• Occasional taunts or verbal outburst • Withholding of information to disempower	• Treatment that undermines dignity and esteem • Denying or failing to recognise Adult's choice or opinion • Frequent verbal outbursts or harrassment	• Humiliation • Emotional blackmail e.g. threats of abandonment/harm • Frequent and frightening verbal outbursts	• Denial of basic human rights/civil liberties, over-riding advance directive, forced marriage • Prolonged intimidation • Vicious/personalised verbal attacks
Financial	• Staff personally benefit from users funds e.g. accrue 'reward' points on their own store loyalty cards when shopping • Money not recorded safely or properly • Non payment of care fees	• Adult not routinely involved in decisions about how their money is spent or kept safe - capacity in this respect is not properly considered	• Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest • Adult denied access to his/her own funds or possessions	• Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control • Personal finances removed from adult's control	• Fraud/exploitation relating to benefits, income, property or will • Theft
Neglect	• Isolated missed home care visit where no harm occurs • Adult is not assisted with a meal/drink on one occasion and no harm occurs • Adult not bathed as often as would like - possible complaint	• Inadequacies in care provision that lead to discomfort or inconvenience - no significant harm occurs e.g. being left wet occasionally • Not having access to aids to independence	• Recurrent missed home care visits where risk of harm escalates, or one miss where harm occurs • Hospital discharge without adequate planning and harm occurs	• Ongoing lack of care to the extent that health and wellbeing deteriorate significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/confidence	• Failure to arrange access to lifesaving services or medical care • Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk
Institutional (any one or combination of the other forms of abuse)	• Lack of stimulation/opportunities for people to engage in social and leisure activities • Service users not given sufficient voice or involved in the running of the service	• Denial of individuality and opportunities for service users to make informed choices and take responsible risks • Care-planning documentation not person-centred	• Rigid/inflexible routines • Service users' dignity is undermined e.g. lack of privacy during support with intimate care needs, sharing under-clothing	• Bad practice not being reported and going unchecked • Unsafe and unhygienic living environments	• Staff misusing their position of power over service users • Over-medication and/or inappropriate restraint used to manage behaviour • Widespread, consistent ill treatment
Discriminatory	• Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences	• Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period • Occasional taunts	• Inequitable access to service provision as a result of a diversity issue • Recurring failure to meet specific care/support needs associated with diversity	• Being refused access to essential services • Denial of civil liberties e.g. voting, making a complaint • Humiliation or threats on a regular basis • Recurring taunts	• Hate crime resulting in injury/ emergency medical treatment/fear for life • Hate crime resulting in serious injury or attempted murder/honour-based violence

Stephen Hoskin Video	
What was the name of the guidance mentioned in the video that is under review?	
What went wrong in the case?	
What was not considered or considered and not addressed and how could we remedy this?	
What might you have considered if your service had been working with Stephen Hoskin?	
What might you do if a referral was not taken to safeguarding and your concerns remained and / or increased?	

The Shape of My Learning

What agreed (or squared) with what you already knew about Safeguarding Adults

What do you now see from a different perspective?

What questions would you like answered this afternoon?

What new directions and actions will you take as a result of this workshop?

Case Study A

Part One

You are the manager of a residential care home. The senior carer has informed you that she forgot to give Mrs Adams her codeine phosphate on Saturday evening. When she realised her mistake the next morning she phoned out of hours to check if there would be any problems because the medication was missed (there wasn't) and recorded this on Mrs Adams notes.

1. Use the risk support tool to help you decide whether you will make a safeguarding referral.

2. If you are making a referral give your reasons

3. If you aren't making a referral what would you do instead?

Case Study A

Part Two

You pass Mrs Adams' room the next week and hear the same senior carer talking to Mrs Adams in a raised voice. She is standing over her and you hear her say. 'You can't go to the toilet now. It was you wanting to go to the toilet that got me into trouble last week.'

Mrs Adams is heard to ask 'What do you mean?'

'You know what I mean', the carer replies, You made me forget to give you your tablet, and Mr Green next door his. So you'll just have to wait. And anyway, if you need to, you can go in your pad.'

This is the first time you've heard about Mr Green missing his medication. He is on tablets (Atenolol) for his blood pressure, which can get dangerously high. When you look at the records you notice that this isn't the first time that this medication has been missed.

4. Use the risk support tool to help you decide whether you will make a safeguarding referral.

5. If you are making a referral give your reasons

6. If you aren't making a referral what would you do instead?

Case Study C

Part 1

Sarah Collins has Down's syndrome and lives in a supported living unit. She has some communication problems and uses Makaton. Sarah enjoys sitting with the other tenants, including George, who also has a tenancy in the unit. You are on duty one evening and you hear George say to Sarah in front of the other tenants 'You have nice boobs'. Sarah blushes and leaves the room.

7. Use the risk support tool to help you decide whether you will make a safeguarding referral.

8. If you are making a referral give your reasons

9. If you aren't making a referral what would you do instead?

Case Study C

Part 2

The next week Julie, another tenant, comes up to you and says she saw George the previous evening in Sarah's room. She tells you she 'thinks it was wrong what George did' because her Mum told her 'you shouldn't let men touch you down there.' You have noticed that Sarah has been quite tearful for the past few days and has had a poor appetite. This is not like Sarah. She is also reluctant to go to bed, where previously she always went to bed at 10.30pm, after watching the 10 o'clock news.

10. Use the risk support tool to help you decide whether you will make a safeguarding referral.

11. If you are making a referral give your reasons

12. If you aren't making a referral what would you do instead?

Independent Safeguarding Authority (ISA)

Guidance documentation

Care Quality Commission (CQC)

Guidance Documentation

Ofsted Safeguarding Adults

Guidance Documentation

Parallel Process

(Consider what you may be doing alongside the safeguarding process including support, reporting, preparing documentation and the documentation required, considerations for adult at risk, staff issues such as disciplinary and support process)

If Safeguarding occurs	If Safeguarding does not occur

Capacity and Consent

Safeguarding Adults (ADSS 2005) states that 'Everyone has a right to follow a course of action that others judge to be unwise or eccentric, including one which may lead to them being abused.' However it goes on to state that, 'Where a person chooses to live with a risk of abuse the safeguarding (care) plan should include access to services that help minimise the risk.'

Consent where the adult at risk has capacity

If the adult has mental capacity to make an informed decision about the concerns facing them and the choices they have the following will need to be determined:

- Whether the person did give consent to the action or actions that were suspected or alleged as being abusive;
- If consent was given does the adult choose to continue to live with the risks they face and in what could be an abusive situation and whether they are willing to participate in the safeguarding process;
- Whether they agree to an investigation being carried out.

Where the rights of others may be compromised by not sharing information, e.g. in a care setting or where others may be at risk, there will be a duty for the partnership organisations to intervene regardless of the adult's wishes.

In some cases, e.g. domestic abuse, the police may still take the decision to pursue a conviction if they consider it a suitable course of action.

Where the adult who has capacity chooses to live with risk and will not agree to investigation, they must be offered support to help them understand those risks and how to minimise them. Partnership professionals will need to consider validity of consent. Did they make this choice of their own free will, or have they been exposed to coercion or intimidation. Efforts should be made to offer the adult distance from the situation in order to facilitate more informed decision making.

Where coercion or intimidation is suspected and significant risk of harm exists, the partners need to agree the best mechanism for monitoring the situation and offering intervention and support. An over-riding duty of care to the individual and other adults at risk and/or children may exist. Where any doubt on how to proceed in such situations, the partnership professionals should always, without exception, seek advice, including legal advice when necessary.

Where the adult at risk has capacity and consents to the sharing of information and to the investigation.

In this case Safeguarding Procedures need to be followed. The adult at risk should be included as a partner, although this may not always be practicable, e.g. if this would put the adult or others at risk or evidence could be contaminated.

Where the adult at risk does not have capacity

The mental capacity act 2005 allows for the safeguarding agencies to act in the person's best interests to do whatever is necessary to protect their safety, health and well-being and promote their continued independence.

Any action must be proportionate to the perceived extent and risk of seriousness of the alleged abuse. Capacity should be assumed unless proven otherwise.

Mental Capacity Act 2005

The act sets out a single, clear, 2 stage test for assessing where a person lacks capacity to take a particular decision at a particular time.

Stage 1

Is there an impairment of, or disturbance in the functioning of the person's mind or brain? It does not matter if this is permanent or temporary.

Stage 2

Is the impairment sufficient to cause the person to be unable to make that particular decision at the relevant time?

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

1. Understand the information relevant to the decision to be made.
2. Retain that information for long enough for the decision to be make
3. Use or weigh that information as part of the decision making process and
4. Communicate their decision.

Best Interests Checklist

The following factors need to be taken into account when determining if what is being done is in that person's best interests. The Mental Capacity Act Code of Practice contains a Best Interest Checklist. Factors when considering best interest include.

1. Consider all relevant circumstances.
2. Can the decision be put off until the person regains capacity?
3. Permitting and encouraging participation, e.g. finding appropriate means of communication or using other people to help the person participate.
4. Special considerations for life-sustaining treatment.
5. Consider the person's wishes, feelings, beliefs and values.
6. Take into account the views of other people.
7. Taken into account the view of an IMCA, if appointed
8. Consider if there is a less restrictive alternative or intervention that is in the person's best interest.

The role of an Independent Mental Capacity Advocate (IMCA) in Safeguarding

Regulations state that an IMCA can become involved when a person lacks capacity and where safeguarding adult proceedings have been instigated. People at risk can be supported by an IMCA regardless of involvement of family or friends. IMCAs can be instructed where there is a reasonable belief that the person lacks capacity in relation to a possible protective measure. Generally the chair of the safeguarding adults proceedings should instruct the IMCA.

Case Study – Capacity and Consent

Look again at all the information given on case study A – Mrs Adams.

You speak to Mrs Adams and she tells you that the carer gets a bit 'rough' with her at times but that it is 'just her way' and she'll 'put up with it because she doesn't want to make a fuss.' Mrs Adams is physically very frail but has capacity.

Questions

1. Can a referral be made for Mrs Adams without her consent?

2. What factors did you consider when making your decision?

3. Would your answers to the above questions be different if Mrs Adams lived at home and it was her son who she was saying this about?

Community Care Magazine – Fiona Pilkington SCR Questions Safeguarding Adults Policy

A serious case review into the case of a mother who killed herself and her disabled daughter after suffering years of harassment from a local gang has questioned the ability of safeguarding adults policies to protect vulnerable victims of antisocial behaviour.

The SCR was published this week after an inquest jury ruled that Pilkington had killed herself and 18-year-old Francesca Hardwick in October 2007 due to the ongoing antisocial behaviour they and Pilkington's severely dyslexic son Anthony had faced over more than 10 years.

Police and councils slammed

The jury slammed Leicestershire Police for failing to respond to Pilkington's complaints and also criticised the response of Leicestershire Council and Hinckley and Bosworth Council, the district council responsible for tackling antisocial behaviour in Barwell, where the family lived.

The SCR, published by Leicester, Leicestershire and Rutland Safeguarding Adult Board, said police responded to over 70% of antisocial behaviour incidents relating to the family.

Partnership working lacking

But the police management review, which fed into the SCR, found that each incident was taken in isolation and there appeared to be no recognition of the family's possible vulnerability, and acknowledged that "partnership working was lacking at various points in their interventions".

No referrals were made to Leicestershire Council social services during 2007, when 13 incidents of antisocial behaviour regarding the family were recorded by police.

But the SCR concluded that had one been made, it would probably have been taken as a request for services, not a multi-agency safeguarding matter as "no abuse had taken place within the family or professional support system".

It said only a "much more rounded assessment" than would have been provided through social care would have identified "significant problems".

Concerns raised about No Secrets

The SCR also raised concerns about the national basis for safeguarding vulnerable adults, the 2000 No Secrets guidance, because it defined vulnerability in terms of eligibility for adult social care, potentially excluding those deemed ineligible.

In this case, a focus on "individual or family vulnerability, regardless of eligibility or presenting need for specific care services" would have been more likely to trigger a safeguarding response.

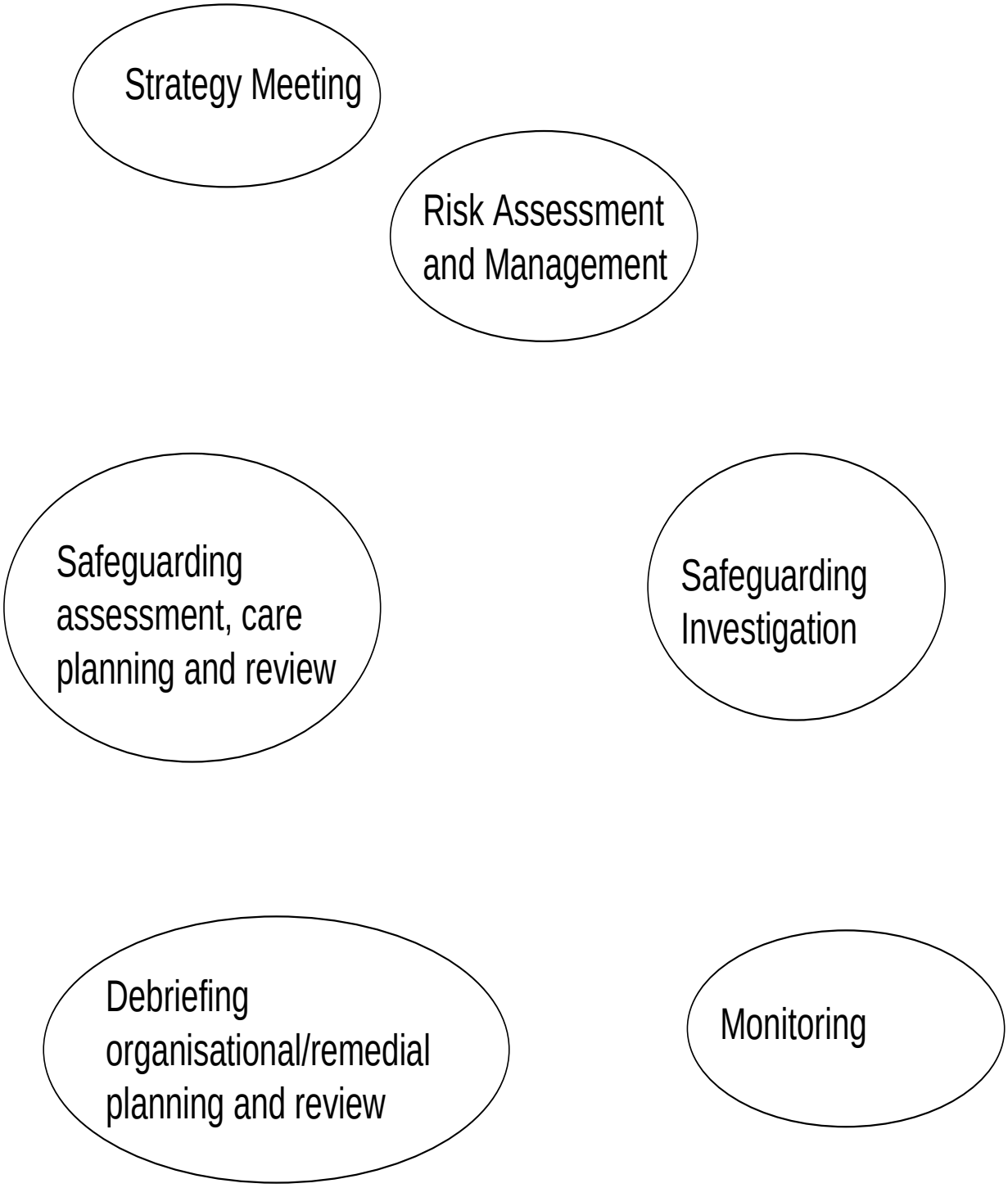
Its key recommendation was for the adult safeguarding board to examine whether its current definition of vulnerability was inclusive enough and whether current procedures enabled "effective responses to individuals or families subject to significant community pressures".

Antisocial behaviour focus

http://www.communitycare.co.uk/Articles/2009/09/30/112729/fiona-pilkington-scr-questions-safeguarding-adults-policy.htm?printerfriendly=true

Discuss:

- cumulative risk
- risk support tool and the importance of impact on individuals
- number of contacts to agencies
- number of police calls
- number of contacts with GP regarding stress and indicators of abuse



You have been given a sheet with the safeguarding process outlined. Note down some of the main points and how you in your role may be involved in each part of the process.

For Accredited Training

7hr Managing the Alert Training, distance learning support material.

Assessment Methods:

Anonymised case study to look at the decision making process around a safeguarding referral

Making the decision to make a Safeguarding Adult Referral: Managing initial risks - 1,000 words

Anonymised evidence of assessing risk relative to organisational context: Nursing, Health & Social Care, Social Work, Occupational Therapy - within care assessment / care plan process; Police - evidence of rationale for making a safeguarding referral or a vulnerable adult referral including legal decision making process; Education – differentiation, safeguarding issues, evidence of equality impact assessment identified on Schemes of Work and Lesson Plans and recording relating to a referral.

Anonymous evidence of supervision or debriefing session following decision making process, signed by line manager.