Stockport Safeguarding Adults Board

Safeguarding Adults at Risk

The Multi-Agency Policy for Safeguarding Adults at Risk

&

Multi Agency Operational Procedures for Responding to and Investigating Abuse.

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1.1 What are Stockport’s Multi-Agency Policy and Procedures?

The Stockport Multi-Agency Safeguarding Adults Policy and Procedures is the local code of practice that has been formulated and agreed in by the Safeguarding Adults Board in accordance with the Care Act 2014. This is the updated 2016 3rd edition and replaces all previous guidance on adult protection and safeguarding in Stockport.

This document reflects the recognition that adults at risk (see below for definition) can suffer abuse, ill treatment and discrimination and that these represent an infringement of their human and civil rights. The policy recognises that all people have the right to live their life free from abuse and free from the fear of abuse.

The policy is concerned with adults at risk in Stockport who are unable without assistance to protect themselves from abuse. This policy and procedures makes a clear distinction between the broader safeguarding agenda for all Adults at Risk, and the Adult Protection operational procedures that should be invoked in individual cases of suspected or actual abuse of an adult at risk.

All activity undertaken within the policy and procedure will be carried out in a way that is appropriate to the level of understanding, degree of disability, means of communication, ethnic and cultural background, gender or sexual orientation of the person concerned.

1.2 Definitions of Adult at Risk, Abuse, Harm, Significant Harm and Dignity

1.2.1 Adult at Risk

The term ‘Adult at Risk’ is used throughout this policy but is interchangeable with term ‘Vulnerable Adult.

Care Act 2014 section 42 (1) states Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the Local Authority is meeting any of these needs) and;
- is experiencing, or at risk of abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect.

The Care Act defines an Adult at Risk as a person aged 18 or over whom:

- is aged 18 or over but stills receives children’s services *(the level of care and support is not relevant, and the young adult does not have to have eligible needs for care and support under the Care Act, or be receiving any particular service from the Local Authority , in order for the safeguarding duties to apply- as long as the conditions set out above are met)
- is eligible for or receives any adult social care service* (including carers services) provided or arranged by the local authority or
- receives Direct Payments in lieu of Adult Social Care services or
• funds their own care and has social care needs or
• otherwise has social care and/or health needs that are low, moderate, substantial or critical
• falls within any other category prescribed by the secretary of state
• is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse by the cared for person
• Is unable to demonstrate the capacity to make a decision and is in need of care and support.

This does not mean that just because a person is old or frail or has a disability that they are inevitably ‘at risk’. For example, a person with a disability who has mental capacity to make decisions about their own safety would be perfectly able to make informed choices and protect themselves from harm. In the context of Safeguarding Adults, the vulnerability of the adult at risk is related to their care needs and how able they are to make and exercise their own informed choices, free from duress, pressure or undue influence of any sort, and to protect themselves from abuse, neglect and exploitation.

It is important to note that people with capacity can also be vulnerable.

1.2.2 Abuse, Harm, Significant Harm and Dignity

For the purpose of this policy and procedures the term abuse is defined as:

‘An act or omission, a violation of an individual’s dignity, human or civil rights, by any other person or persons which results in significant harm to the physical, emotional or social wellbeing of an adult at risk’.

Key concepts in adult safeguarding work are ‘Harm’ and ‘Significant Harm’. They help to determine the seriousness and extent of abuse and assist in determining the level of intervention. However the distinction between harm and significant harm should not be the sole means in determining whether or not abuse has occurred.

Harm (regardless of whether the impact of this is a significant or not) is defined as:

• ill treatment (including sexual abuse and forms of ill-treatment that are not physical)
• the impairment of development and/ or an avoidable deterioration in, physical or mental health
• the impairment of physical, emotional, social or behavioural development or the impairment of health
• unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion)


Significant Harm

The impact of harm upon a person will be individual and depend upon each person’s circumstances and the severity, degree and impact or effect of this upon that person. The concept of ‘significant harm’ is therefore relative to each individual concerned.

The difference between harm and significant harm is not always clear at the point of the alert or referral. All reports of suspicions or concerns should be approached with an open mind and could give rise to action under the policy and procedures.
Dignity

Being treated with dignity and respect is a human right. The opening sentence of the United Nations Universal Declaration of human rights declares that;

‘Recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world’.

Dignity, quality and safeguarding are inextricably linked in the provision of services to adults at risk. Treating people with respect and therefore helping them retain their dignity and self-respect is an important aspect of the quality of services provided by both health and care providers. Corporate neglect is often the result of not putting dignity at the core of service provision.

For further information regarding harm, please see the Harm Level Guidance-

1.3 The Aim of the Policy & Procedures

This policy in line with the Care Act 2014 recognises that adults at risk can suffer abuse, ill treatment and discrimination, and that this is an infringement of their human and civil rights. This policy aims to make sure that:

- **Practice is person led and outcome focused; ensuring** the adult at risk is supported to maintain choice and control
- the needs and interests of adults at risk are always respected and upheld
- the human rights of adults at risk are respected and upheld
- the dignity of adults at risk is respected and upheld
- the prevention of abuse where possible is a key priority for all services
- a proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse
- all relevant decisions and actions comply with the Mental Capacity Act 2005
- The health and safety of the adult at risk is paramount.

1.4 Who is expected to Comply with this Policy and Procedures?

- All statutory organisations delivering Health and Social Care in Stockport (see 3.1.1)
- All organisations from which services are commissioned by the statutory Health and Social Care organisation.
- Any other organisation working with adults at risk in Stockport.

Additionally each organisation should have its own internal procedures and guidelines informing their staff of their responsibilities to protect adults at risk and specifying how these relate to Stockport’s multi agency policy and procedures.

These multi-agency procedures should also be used in conjunction with individual organisations procedures on related issues such as domestic violence, fraud, disciplinary procedures and health and safety.
In complying with the policy and procedures all organisations and individuals confirm their commitment to:

- Work together on the prevention, identification and investigation of abuse and the protection and support of people who may be at risk.
- Maintain a dialogue at both strategic and operational levels to ensure multi-agency cooperation.
- Share information within legal and professional constraints.
- Ensure that staff – both in commissioned and directly provided services - understands the policy and procedures and implement it consistently.
- Contribute to the monitoring and evaluation of the implementation of the policy and procedures.
- Identify the resources required, within acknowledged constraints, to meet these commitments.
- Recognise that the right of self-determination can involve risk and ensure that such risk is acknowledged and understood and appropriate steps taken to minimise the risk once it has been identified.

1.5 Relevant Training

The Care Act 2014 requires that all those involved in the provision of health and social care will undergo appropriate training to ensure all staff meet the relevant level of competency in relation to safeguarding adults at risk.

For detail of available training go to: www.stockport.gov.uk/staffdevelopment

1.6 What are the Guiding Principles Which Underpin this Policy and Procedures?

By implementing this policy and procedures to safeguard the basic human rights of individuals in our society, we have agreed the following principles as set out in the care act 2014

- **Empowerment** - Presumption of person led decisions and informed consent.
- **Prevention** - It is better to take action before harm occurs.
- **Proportionality** - Proportionate and least intrusive response appropriate to the risk presented.
- **Protection** - Support and representation for those in greatest need.
- **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.

In order to effectively implement these guiding principles it is of paramount importance that at all times, the adult at risk and/or their representatives are fully supported to engage in the adult protection process.

Making Safeguarding personal

Making Safeguarding Personal is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in
safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Making Safeguarding Personal is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people’s lives. It is a shift from a process supported by conversations to a series of conversations supported by a process.

1.7 Why do we need this Policy and Procedures?

This policy lays out locally agreed multi-agency procedures so that NHS Services, Adult Social Care, the Police, local Independent, Statutory and Voluntary organisations can work together to safeguard and protect adults at risk from abuse.

There are many advantages to a multi-agency approach including:

- Having an overview of a person at risk’s vulnerability through sharing information between organisations.
- A reduction in the number of interviews conducted.
- A clearer understanding of agency roles in dealing with abuse.
- Co-ordinated service delivery to the abused person and carer.
- Shared responsibility for working with people who have experienced abuse.
- An assurance that procedures for protection and care of vulnerable adults are consistently implemented and understood.
- The process being monitored.

1.8 What are the Rights of the Individual?

The policy and procedure is a practical expression of the commitment to ensure that individual rights are recognised and upheld. All people have the right to:

- Be treated with dignity at all times.
- Respect from their families and carers, and professionals and volunteers providing services for them.
- The freedom to express their thoughts and feelings providing this does not break the law or infringe other people’s rights.
- Be meaningfully involved in making decisions that affect their lives.
- Personal privacy, including not having personal letters opened or phone calls listened to unless the law allows this.
- Be included in the activities and opportunities of ordinary living.
- Information, especially concerning things that would make life better for them.
- Adequate standards of living, good food, access to health care and freedom from neglect.
- Opportunities and support to become as independent and active as possible and to develop their full potential.
- Safety, adequate care and protection from all forms of violence, including physical punishment, intimidation, harassment, belittling, and sexual assault.
- To access the criminal justice system if a crime is believed to have been committed.
- Leisure time activities of their choice, including those with an element of risk.
- Retain money and property that is legally theirs.
• To be free from discrimination on the grounds of ethnic origin, culture, religion, gender, sexuality, age or disability.

All adults should be enabled to take control of their lives. The challenge for the implementation of this policy and procedure is to achieve the right balance between protecting individuals and enabling them to manage their own risks. In doing this individuals need to be at the centre of making any decisions that affect them.

This policy and procedures will be implemented with due regard to equality of opportunity and where appropriate will take into account the statutory rights of carers. This will include work undertaken in partnership with carers wherever it is in the interests of the adult at risk.

1.9 The Safeguarding Adults Board – Remit

The Care Act 2014 puts Adult Safeguarding on a legal footing. From April 2015 the Stockport Safeguarding adults Board became a legal entity with core membership from the local authority, the Police and the NHS (specifically the local Clinical Commissioning Groups).

The SAB must lead adult safeguarding arrangements across Stockport and oversee and coordinate the effectiveness of the safeguarding work of its members and partner agencies. The Board will work to promote the wellbeing, security and the safety of vulnerable people, recognising their rights, mental capacity and personal responsibility in order to help prevent abuse wherever possible.

Under the Care Act 2014 SAB has three core duties. It must:

• develop and publish a strategic plan setting out how it will meet its objectives and how its members and partner agencies will contribute
• publish an annual report detailing how effective its work has been
• commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these (please see supporting documents for criteria and how to make a SAR referral)

In addition the SSAB should evidence its arrangements for peer review and self-audit and evidence how SSAB members have challenged one another and held each other account.

1.10 Complaints and Appeal Process

Any complaints relating to investigations of abuse under this policy and procedures will be dealt with through the existing complaints processes within Stockport Councils Adult Social Care or Pennine Care NHS Foundation Trust.

However the Safeguarding Adults Board will maintain an overview of all complaints made and the responses given.
# Part 2 – Key Issues for Safeguarding in Stockport

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2.1 What is Abuse? – Categories and Indicators

2.1.1 Abuse may be:

- A single act or repeated acts
• An act of neglect or a failure to act
• Multiple acts, for example, an adult at risk may be neglected and also being financially abused.

Abuse is about the misuse of power and control that one person has over another. Where there is dependency, there is a possibility of abuse or neglect unless adequate safeguards are put in place. Intent is not an issue at the point of deciding whether an act or a failure to act is abuse; it is the impact of the act on the person and the harm or risk of harm to that individual.

Abuse can take place in settings such as the person’s own home, day or residential centres, supported housing, educational establishments, or in nursing homes, clinics or hospitals.

What constitutes abuse or neglect should not be considered in isolation. Abuse and neglect can take many forms and the circumstances of each individual must always be considered.

A number of abusive acts are crimes and informing the police must be a key consideration.

2.1.2 Categories and indicators of Abuse

There are ten categories of abuse in the policy which are listed below with possible indicators for each type of abuse.

The presence of one or more indicators does not necessarily mean that a vulnerable person is being abused; however, they may reflect the potential for abuse in a given situation and suggest the need for further investigation. Different indicators of abuse are not mutually exclusive to one category and the same indicators may present across the various categories of abuse.

2.1.2. (i) Physical abuse

Physical abuse is any abuse which has a physical impact on that individual, this includes:

• Hitting, slapping, kicking, shaking, pinching, dragging, pulling or pushing
• Burning or scalding
• Force feeding or tampering with food
• Misuse or mal-administration of medication
• Inappropriate restraint or treatment*
• Inappropriate moving and handling/rough handling
• Inappropriate isolation or confinement
• Withdrawal of sensory or mobility aids.
• Honour based violence.

*Restraint

Inappropriate use of restraint or physical interventions and/or unlawful deprivation of liberty is physical abuse. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence. Someone is using restraint if they use force, or threaten to use force, to make someone do something they are resisting, or where a person’s freedom of movement is restricted, whether they are resisting or not. Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something, or does not do something they want to do. Appropriate use of restraint can be justified to prevent harm to a person who lacks capacity as long as it is a proportionate response to the likelihood and seriousness of the harm. Providers of health and social care must have in place internal operational procedures covering the use of physical interventions and restraint incorporating best practice guidance and the
Mental Capacity Act, Mental Capacity Act Code and the Deprivation of Liberty Safeguards (DoLs) (see below).

Please note appropriate use of restraint can be justified to prevent harm to a person who lacks capacity as long as it is a proportionate response to the likelihood and seriousness of the harm. Such practice should be clearly documented, stating who the decision maker is and how the less restrictive option was determined.

Deprivation of Liberty Safeguards (DOLS)

These safeguards provide protection to people in hospitals and care homes who do not have the capacity to consent to their care and treatment and the manner in which it is provide.

In March 2014, the Supreme Court handed down judgment in two cases: *P v Cheshire West and Chester Council and P & Q v Surrey County Council.* That judgment, commonly known as *Cheshire West* has led to a considerable increase in the numbers of people in England and Wales who are considered to be deprived of their liberty for the purposes of receiving care and treatment. The Supreme Court decided that when an individual lacking capacity was under continuous or complete supervision and control and was not free to leave, they were being deprived of their liberty. This is now commonly called the “acid test.”

Any Adult at Risk who is detained without consent for the purpose of care or treatment should be deprived of their liberty via a legal means. The legal means available for such actions are a DOLS authorisation, detention under the Mental Health Act 1983, or an order by the Court of Protection.

Care Homes and hospitals must make requests to the Supervisory Body for authorisation to legally deprive someone of their liberty if they believe it is in their best interests. All decisions on care and treatment must comply with the Mental Capacity Act.

Stockport’s Supervisory Body is managed by the Adults Safeguarding and Quality Service and can be contacted on 0161 474 3696. Referral forms must be sent to DoLSreferrals@stockport.gov.uk for new Deprivation of Liberty Safeguard authorisations.

Physical Abuse Possible Indicators

- Injuries inconsistent with or not fully explained by the account given.
- Different accounts of the injuries given to different people.
- Injuries inconsistent with the person’s lifestyle
- History of unexplained injuries or falls.
- Bruising on the torso, back, buttocks or thighs or in well protected areas such as the inside of the leg or upper arm or on each side on soft parts of the body.
- Bruising clustered from repeated striking.
- Injuries or bruising at different stages of healing.
- Marks on the body in the shape of an object.
- Finger mark bruising.
- Fractures, especially if these are in different stages of healing.
- Multiple or spinal injuries.
- Burns, including scald marks, rope burns, carpet burns, electrical appliance burns.
- Unexplained hair loss in clumps.
- Cuts or abrasions to the mouth, lips, gums, eyes or external genitalia.
- History of changes of GP or social care agencies.
- Signs of misuse of medication such as over or under medication.
• Lack of personal care, inadequate or inappropriate clothing, inadequate heating, left in wet clothing.
• Subdued behaviour in presence of the carer.
• Urinary or faecal incontinence.
• Malnutrition – rapid or continuous weight loss, complaints of hunger.
• Use of furniture and other equipment to restrict movement.

2.1.2 (ii) Domestic Abuse

Domestic abuse includes psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence; Female Genital Mutilation; forced marriage. Domestic abuse is not only between intimate partners, other family members can be considered perpetrators of domestic abuse.

The Home Office 2013 defines domestic abuse as:

• Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse.... By someone who is or has been an intimate partner or family member regardless of gender or sexuality, who is 16 years old and above.

Domestic abuse is multifaceted in its presentation please see all other categories of abuse for possible indicators of Domestic abuse.

2.1.2 (iii) Neglect and Acts of Omission

Neglect is failing to provide an adequate standard of care. It may occur deliberately or by omission, and it includes:

• Failure to provide essential nutrition, clothing, medication and heating.
• Ignoring physical or medical care needs.
• Ignoring emotional care needs
• Denying access to medical, psychiatric, psychological or social care.
• Failure to assess risk or to intervene to avert or reduce danger.
• Failure to access assessments or technical aids (e.g. hearing test/aids).
• Failure to access to educational services
• Failure to give privacy and dignity in delivery of care.

2.1.2 (iv) Self-neglect

The Care Act 2014 formally recognises self-neglect as a category of abuse. Adults who self-neglect can now be supported through intervention under safeguarding adults procedures.

The term ‘self-neglect’ refers to an unwillingness or inability to care for oneself and/or one’s environment. It encompasses a wide range of behaviours, including hoarding, living in squalor, and neglecting self-care and hygiene

Self- neglect is a difficult issue to address in practice, not least because people who self-neglect may not see that they are living with self-neglect. There are questions of personal choice and how to provide help and support to someone who may not want it. In addressing self-neglect under this policy and procedure the response must be proportionate to the risk of harm to the mentally capacitated individual.
Neglect - possible indicators

Factors that may indicate neglect include:

- Malnutrition, rapid or continuous weight loss, complaints of hunger or thirst.
- Dehydration.
- Poor personal hygiene.
- Untreated pressure sores.
- Indications of untreated medical problems.
- Signs of mal-administration of medication.
- Failure to provide hearing aids, mobility aids, glasses and dentures.
- Clothing and bedding dirty, wet, soiled, inadequate or inappropriate.
- Accommodation in poor state, inadequate heating or lighting.
- Failure to adhere to agreed care plans and risk assessments.
- Failure to ensure appropriate privacy and dignity.
- Person is exposed to unacceptable risk.

2.1.2 (v) Sexual abuse

Sexual abuse is involving people in sexual activity without their voluntary and informed consent and may also include sexual activity where one party is in a position of trust, power or authority. Sexual abuse includes:

- Vaginal or anal rape
- Inappropriate looking or touching
- Denial of a sexual life
- Incest
- Indecent assault
- Gross indecency
- Sexual harassment
- Coercion or undue influence to engage in sexual activity.
- Sexual teasing or innuendo
- Sexual harassment
- Sexual photography
- Exposure to sexual explicit materials or situations
- Forced marriage
- Sexual activity with a person who lacks the mental capacity to consent.

Professional Relationships

All sexual activity involving staff with individuals for whom they care, or know to be vulnerable is contrary to professional standards. It is abusive and will result in disciplinary proceedings.

Sexual abuse – possible indicators

Factors that may indicate sexual abuse include:

- Full or partial disclosure or hints of sexual abuse.
- Bruising, bleeding or pain in genital, vaginal or anal area.
- Bruising of upper thighs or upper arms.
- Unexplained difficulty in sitting and walking.
- Love bites.
- Sexually transmitted diseases.
- Urinary tract infection or vaginal infection.
• Pregnancy in a person who is unable to consent to sexual relations.
• Persistent unexplained removal of urinary catheters.
• Wetting or soiling when no history of incontinence.
• Torn, stained or bloody underclothing or bedding.
• Overt sexual behaviour or language.
• Unexplained behaviour or mood change.
• Obsession with washing.
• Reluctance to be alone with an individual known to them.
• Fear of caregiver offering help with personal care.
• Signs of depression or stress.

2.1.2 (vi) Psychological or emotional abuse

Psychological or emotional abuse is behaviour that has an adverse effect on an individual’s mental well-being. It includes:

• Bullying and aggression.
• Inappropriate befriending
• Threats and intimidation of harm and or abandonment
• Derivation of contact
• Isolation
• Unreasonable and unjustified withdrawal of services or supportive networks
• The denial of basic human and civil rights such as self-expression, privacy and dignity.
• Humiliation, ridicule and name calling.
• Exclusion from group or marginalisation.
• Denial of access to social contact, cultural or religious observance or possessions.
• Disregard of choice and consent.
• Verbal abuse.
• Cyber bullying
• Grooming, recruiting and encouraging participation in acts of violence or violent extremism – (The Channel Process - see section 2.10 for more information)
• Forced Marriage – this is a violation of internationally recognised human rights and contrary to Matrimonial Causes Act 1973. – comes under Domestic Abuse

Psychological abuse – possible indicators

Factors that may indicate psychological or emotional abuse may include:

• Fear, watchfulness or agitation
• Deference, resignation and passivity
• Excessive loyalty and over-anxious to please
• Oppressive atmosphere or tension in the presence of certain others
• Low self-esteem
• Loss of interest, emotional withdrawal or symptoms of depression
• Sleep disturbance
• Significant weight loss or gain
• Over controlling behaviour by third party
• Self-harm
• Denial of access to the vulnerable adult
• Social isolation
• Lack of consideration for the vulnerable adult
• Denial of privacy, choice, freedom of movement
• Denial of religious or cultural needs
• Restricting access to sensory, mobility or continence aids or equipment
• Decisions always made by others
• Person not allowed visitors/phone calls.

2.1.2 (vii) Financial or material abuse

In many instances financial abuse is a crime and the police should be involved at an early stage if appropriate. Financial abuse is the misuse of a person’s property, assets, income, funds or any resources it includes:

• Theft, misappropriation or withholding of money, possessions or property.
• Mismanagement of finance and property.
• Pressure, by threat or persuasion, to influence wills, inheritance, property or financial transactions.
• The misuse of an enduring power of attorney, a lasting power of attorney, benefits agency appointeeship or court appointed deputyship.
• Denying access to care or accommodation for financial reasons.
• Manipulating or grooming an adult at risk in receipt of a personal budget direct payment.

Professional relationships

It is contrary to professional standards for staff to enter into any kind of financial arrangements with an individual for whom they provide care. This includes knowingly being named as a beneficiary in a will.

Financial abuse – possible indicators

Factors that may indicate financial or material abuse include:

• Unexplained or sudden debts or inability to pay bills.
• Unusual or inappropriate bank account activity.
• Unexplained disappearance of financial documents.
• Disparity between assets and living conditions.
• Extraordinary interest by certain others in person’s assets.
• Financial dependency of others on the vulnerable adult.
• Person managing financial affairs is evasive or uncooperative.
• Enduring Power of Attorney or Lasting Power of Attorney obtained or wills signed when the person lacks mental capacity.
• Unexplained arrival of bills, credit card bills.
• Denial of access to funds or documentation.
• Changes to wills or deeds of title.
• Responsible person(s) fail(s) to account for expenses incurred on behalf of other(s).

2.1.2 (viii) Discriminatory abuse

Discriminatory abuse exists when values, beliefs and culture result in a misuse of power that denies opportunity to individuals or groups.

A person may be exploited or targeted by others who have a negative view of the individual based on the following factors:

• Gender and gender identity
• Sexuality
• Culture
• Ethnicity
• Sexual orientation i.e. lesbian, gay, bi-sexual, transgender
• Age
• Disability as a result of physical condition or cognitive impairment
• Religious observance
• Political affiliation.
• Race

Factors which may indicate discriminatory abuse may include:

• A failure to support the adult at risk to communicate in the language or medium most appropriate to them
• Loss of weight through lack of provision of culturally appropriate diet
• Anxiety/depression through lack of opportunities for religious observance
• Excluded from decision making
• Poor health as a consequence of poor care standards
• Failure to protect or provide redress through the criminal or civil justice system
• Denial of sexual expression
• Inappropriate use of language
• Delivery of personal care without reference to gender
• Harassment

Hate Crime

A specific manifestation of discriminatory abuse is recognised within the criminal justice system under the category Hate Crime.

Hate Crime is defined as any incident that is perceived by the victim, or any other person to be targeting that individual on the grounds of sexual orientation, transgender identity, religion or belief, race or ethnicity and disability. This can include incidents of anti-social behaviour which do not always constitute a criminal offence. The police have special procedures to respond to reports of hate crime appropriately. In the event of a perceived hate crime against adults at risk, early contact with the police is vital to ensure appropriate an appropriate response is given.

Please note Greater Manchester Police recognise Alternative sub culture as an additional category of hate crime.

A Hate Crime can manifest itself in the following ways

• Spitting
• Physical attack
• Verbal abuse
• Damage to property including graffiti
• Offensive letter, leaflets, email and texts including the use of social networking sites
• Bullying
• Abusive gestures
• Name calling/harassment abuse.

2.1.2 (ix) Organisational / Institutional Abuse

Organisational/Institutional abuse can be defined, as abuse or mistreatment by a regime as well as by individuals within any health or care setting or persons own home.
Organisational/Institutional abuse violates the person’s dignity, which results in lack of respect for their human rights. Organisational/Institutional abuse may range from a one off incident to ongoing ill treatment. It can be neglect or poor professional practice as a result of the structure, policies, process and practices within an organisation; which result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk.

The risk of organisational/institutional abuse increases in services:

- With poor management.
- With too few staff.
- Which use rigid routines and inflexible practices.
- Where there is a closed culture.
- Where there is poor training of staff.
- Where there is poor supervision of staff and inadequate guidance.
- Where there is a culture of failing to promote people’s rights.
- Where is there is a lack of or poor response to complaints.
- Where there is poor communication between staff, residents, managers, visitors and carers.
- Where there is an inflexible services based on the convenience of the provider rather than the person receiving the services.
- Where there is a lack of adherence to confidentiality.
- Where there is a lack of understanding regarding the importance of person centred planning.
- Where there are out of date/poor care plans, risk assessment and care reviews.

Indicators of institutional abuse:

- Lack of dignity, privacy or respect.
- Lack of opportunity for drinks or snacks outside of main meal times.
- Lack of choice regarding meals.
- Lack of flexibility and choice, excessively rigid routines.
- Lack of opportunity to personalise environment, lack of personal possessions.
- Use of restraint except where there has been clear multi agency risk assessment and planning.
- Lack of choice of same sex staff to undertake intimate personal care.
- Treating adults as children.
- Lack of choice in everyday activities.
- Changes in accommodation (within or between homes) without agreement.
- Denial of individual identity.
- Lack of privacy and personal care.
- Lack of personal clothing or possessions.
- Being left on toilet/commode for long periods.

2.1.2 (X) Modern Slavery

Encompasses slavery, human trafficking, and forced labour and domestic servitude.

Signs of slavery in the UK and elsewhere are often hidden, making it even harder to recognise victims around us.

Modern Slavery -Possible indicators
Factor that may indicate modern slavery:

- Physical Appearance – victims may show signs of physical or psychological abuse, look malnourished or unkempt, or appear withdrawn.
- Isolation-victims may rarely be allowed to travel on their own, seem under the control, influence of others, rarely interact or appear unfamiliar with their neighborhood or where they work.
- Poor living conditions- victims may be living in dirty, cramped or overcrowded accommodation, and/or living and working at the same address.
- Few or no personal effects-victims may have no identification documents, have few personal possessions and always wear the same clothes day in day out. What clothes they do wear may not be suitable of the season or their type of work.
- Restricted freedom of movement- victims have little opportunity to move freely and may have their travel documents retained e.g. passports
- Unusual travel times- may be dropped off and collected for work on a regular basis either very early of late at night.
- Reluctant to seek help- victims may avoid eye contact, appear frightened or hesitant to talk to strangers and fear law enforcers for many reasons, such as not knowing who to trust or where to get help, fear of deportation, fear of violence to them or their family.

2.2 Causes of Abuse

Factors contributing to the occurrence of abuse

The following paragraphs identify some possible causes of abuse. The presence of one or more of these will not necessarily lead to abuse and abuse may occur when none are present. They do reflect, however, some of the stresses that may affect the relationship between people who are dependent on others for their care and those who provide that care and which may, therefore, be predisposing factors for abuse to occur.

Possible causes of abuse within personal relationships (Carer Stress)

A carer is someone who provides care for a relative, friend or neighbour at home. It is recognised that providing care can be very stressful and can occasionally lead to either deliberate acts of harm or an inability to provide appropriate care (omission).

There is no evidence from research that the stress of caring in itself is a cause of abuse. In addition carers may find themselves being abused by the person that they care for and some adults at risk are themselves carers for others.

Section 1 of the Care Act 2014 includes protection from abuse and neglect this includes both the cared for and the carer.

In situations where the abuse occurs within a caring relationship (the victim being either the carer or cared for) the aim of the safeguarding adults protection plan will be to provide support to eliminate abuse to either party and decrease the risk of further harm.

A carer’s assessment should be offered.

Stress may occur within the relationship between an adult at risk and a carer when:

- The nature of the previous relationship has changed from one of equality to one of dependency and care giver.
• The quality of the previous relationship between the adult at risk and the carer was poor or abusive.
• A previous power-abusive relationship is reversed, as when an abusive husband/father becomes dependent on a partner or adult child.
• The carer has a number of other significant dependants.
• The carer or the adult at risk has a mental illness, misuses drugs or alcohol or has a history of violence or sexual offences.
• Living conditions are poor or there are financial difficulties.
• The adult at risk and the carer have different values and standards.
• The carer has had to change their lifestyle unwillingly.
• Incontinence or difficult behaviour is perceived as deliberate.
• The demands of physical and emotional care are considerable.
• The carer feels isolated and unsupported and has no respite.
• Sleep patterns are disturbed.
• Support services are unavailable or are rejected by the adult at risk or the carer.
• Sudden, significant changes such as loss or bereavement affect normal coping mechanisms.

Where a carer causes deliberate harm to an adult at risk the same principles and responsibility for reporting to the police apply as described throughout this policy.

Possible causes of abuse in service settings

Poor quality care in service settings may be a result of inadequate management, poor performance, low staff morale or breakdown in communication whereby:

• Policy and practice guidance, quality standards and monitoring are lacking.
• Staffing levels are inadequate.
• Staff are untrained or unsupported.
• Staff turnover and sickness levels are high.
• Communication between managers and staff is poor.
• Teamwork among staff is poor.
• There is a culture of control between staff and managers or between staff and adult at risk.
• Adult at risk have little opportunity to express their views and wishes.
• Adults at risk are critical about their placement or service delivery.
• Adults at risk are abusive to staff and other service users.

Organizational/institutional abuse may range from one off incidents leading to ongoing ill treatment.

For Adult safeguarding under the Care Act 2014 the responsibility to act first lies with the employing organisation as a provider of the service. When an employer is aware of abuse or neglect they are under a duty to correct this and protect the adult at risk as soon as possible and inform Stockport Local Authority, CCG and CQC. Transparency, open-mindedness and timeliness are important features of fair and effective safeguarding enquiries. In Stockport partners should be aware of the local agreement regarding who needs to notified or involved in safeguarding alerts. Safeguarding procedure should be used in a proportionate way that reflect the principles of the care act and the significance of the harm and risk identified.

For further information in relation to responding to abuse in a service setting please see Harm Levels Guidance.
2.3 Responding to Disclosures

Staff working with adults a risk in any setting may find themselves in a situation in which a person discloses information alleging or suggesting that they have been abused. It is most important that the adult risk is given the fullest opportunity to say what they want to say and that the staff member’s response to the disclosure provides the foundation for appropriate action to be taken within the Safeguarding Adults Policy and Procedures.

Do:

- Remain calm and try not to show any shock or disbelief.
- Listen very carefully to what you are being told.
- Demonstrate a sympathetic approach by acknowledging regret and concern about what has happened.
- Reassure the person that:
  - They have done the right thing in sharing the information with you
  - You are treating the information seriously
  - The abuse is not their fault.
- Be aware that in cases of physical or sexual abuse, medical or criminal evidence may exist and it is important to preserve this.
- Explain that you are required to share the information with your line manager.
- Reassure the person that:
  - Any further investigation will be conducted sensitively and, wherever possible, with their full involvement;
  - Steps will be taken to support and, where appropriate, protect them in the future.
- Report the information to your line manager at the earliest opportunity.
- Record what the person has told you as soon as possible, including the actual words used by the person and precise factual information such as dates and times.
- Sign and date the record, including a note of when and to whom you reported the information.

Do not:

- Stop someone who is freely recalling significant events but allow them to share whatever is important to them.
- Ask the person for more details as this may be done during any subsequent inquiry and it is important to avoid unnecessary repetition for the person concerned.
- Ask questions about the person’s own behaviour or reaction to the abuse.
- Promise to keep secrets.
- Make promises you are unable to keep.
- Contact the alleged abuser.
- Talk to other staff or service users about the information that has been shared with you.

2.4 Mental Capacity and Consent

The assumption is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. However, issues of mental capacity and the ability to give informed consent are central to decisions and actions in Safeguarding Adults. All interventions need to take into account the mental capacity of individual to make informed choices about the way they want to live and the risks they want to take.

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for them and establishes a framework for making decisions on
their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the Safeguarding Adults process must comply with the Act. The Act says that:

“... 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 disturbance in the functioning of the mind or brain”

Further, a person is not able to make a decision if they are unable to:

- understand the information relevant to the decision or
- retain that information long enough for them to make the decision or
- use or weigh that information as part of the process of making the decision or
- communicate their decision (whether by talking, using sign language or by any other means such as muscle movements, blinking an eye or squeezing a hand).

Mental capacity is time and decision specific. This means that a person may be able to make some decisions but not others at a particular point in time. For example, a person may have the capacity to consent to simple medical examination but not to major surgery. Their ability to make a decision may also fluctuate over time.

2.4.1 The five Principles of the Mental Capacity Act 2005

- An adult at risk has the right to make their own decisions and must be assumed to have capacity to make decisions about their own safety unless it is assessed otherwise.
- Adults at risk must receive all appropriate help and support to make decisions before anyone concludes that they cannot make their own decisions.
- Adults at risk have the right to make decisions that others might regard as being unwise or eccentric and a person cannot be treated as lacking capacity for these reasons.
- Decisions made on behalf of a person who lacks mental capacity must be done in their best interests.
- The decision should be the less restrictive of their basic rights and freedoms.

2.4.2 Ill treatment and wilful neglect

An allegation of abuse or neglect of an adult at risk who does not have mental capacity will always give rise to action under the Safeguarding Adults process and subsequent decisions made in their best interests in line with the Mental Capacity Act and Mental Capacity Act Code as outlined above.

Section 44 of the Mental Capacity Act makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.

The Criminal Justice and Courts Act 2015 section 20 and 21 introduces the specific offences of ill-treatment or neglect by care-workers (s 20) or care providers (s 21) which is applicable regardless of the person’s mental capacity.

2.4.3 Consent

It is always essential in safeguarding to consider whether the adult at risk is capable of giving informed consent.
2.4.4 An Adult with Mental Capacity

Points to consider:

- The adult consents to the abusive activity (if consent is believed to have been given under duress, for example, as a result of exploitation, pressure, fear, intimidation or family loyalty, consideration should be given to the need to disregard adult at risks wishes).

- The adult at risk does not consent to a Safeguarding Adults investigation going ahead and there are no public interest issues, risk to others and criminal activity considerations, then their wishes must be respected. However the person must be given the relevant information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the short and long term.

Consent will be required for each of the following:

- The recommendations of an individual protection plan being put in place
- A medical examination
- An interview
- Sharing of information with others.

2.5 Prevention of Abuse

All organisations working with vulnerable adults should ensure they have systems in place to proactively prevent abuse. Section 6 (7) of the Care Act requires Local authorities and their relevant partners to cooperate with each other in the exercise of their functions relevant to care and support inclusive of the protection adults.

The Care Act 2014 requires providers of care and support to prevent abuse wherever possible. Positive early intervention can make a huge difference to people’s lives and the safeguarding outcome.

The following list out lines good practice guidelines which will contribute to the prevention of abuse:

- Rigorous recruitment practices (including volunteers)
- Internal guidelines for employees
- Training
- Information for users, carers and the general public
- Attention to issues relating to protection of vulnerable adults in Direct Payments arrangements Commissioning of services

The Care Act requires all parties to have robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under the Safeguarding adult’s procedures

For further information in relation to responding to abuse in a service setting please see Harm Levels Guidance.

2.5.1 Recruitment and Selection
It is essential all employees are carefully selected and recruited in order to ensure a high quality of service is offered to vulnerable adults and the following addressed.

- **Convictions** - The Rehabilitation of Offenders Act 1974 (ROA Exceptions) Order 1975 as amended by ROA 1974 (exceptions) (Amendment) Order 1986 allows convictions that are ordinarily spent (under the ROA 1974) to be disclosed for the purpose of working with vulnerable people and to be taken into account in deciding whether to recruit an applicant. All applicants should therefore be asked to list all convictions and cautions.

- A past conviction should not in itself preclude employment but consideration must be given as to whether past behaviour of the individual may put the vulnerable adult at risk.

- **References** - All employers should take up references from a minimum of two referees, with one being from the last employer. This should be undertaken before offers of appointment and these should be provided in writing. Prospective employers should make all efforts to ensure references can be checked and are in writing.

- **Disclosure and Barring Service (DBS)** - All prospective staff in regulated activity must have an enhanced DBS disclosure which includes a check whether a person’s name is on either of the Barred Lists maintained by the DBS.

- **Volunteers** - Where volunteers in regulated activity with adults at risk the employing organisation should ensure the same checks are undertaken as with a paid employee. Employers should ensure that volunteers are fully aware of agency polices including those relating to adult protection

### 2.5.2 The Disclosure and Barring Service (DBS)

The DBS role is to help prevent unsuitable people from working with children and vulnerable adults. It assesses those individuals working or wishing to work in regulated activity that are referred to the DBS on the grounds that they pose a possible risk of harm to vulnerable groups. Referral is required where an employer or an organisation, for example, a regulatory body, has concerns that a person has caused harm or poses a future risk of harm to children or vulnerable adults. In these circumstances the employer or regulatory body must make a referral to the DBS. The range of organisations that have this duty to make referrals include:

- Regulated activity providers
- Personnel suppliers
- Local authorities
- Education and Library Boards
- Health and Social Care (HSC) bodies
- Keepers of Registers named in the legislation
- Supervisory authorities named in the legislation.

The DBS replaces all previous vetting and barring schemes including the ISA, POVA list, the POCA List and List 99.

Any inquiry which is considering an allegation of abuse against a paid or voluntary worker must determine whether a referral to the DBS needs to be made and who is to make the referral.

Comprehensive guidance on the scheme in general, the referral process and the referral form can be downloaded from [www.gov.uk/government/organisations/disclosure-and-barring-service](http://www.gov.uk/government/organisations/disclosure-and-barring-service)
In addition Skills for Care has produced a recruitment and retention toolkit for the adult care and support sector. ‘Finders Keepers’ is designed to help care providers, particularly smaller organisations, to improve the ways they recruit staff and retain them.


2.5.3 Health and Care Professions Council (HCPC)

All professionals registered with the HCPC should be familiar with codes of practice and proficiency standards relevant to their role. Compliance with these is expected at all times.

2.5.4 Stockport Safeguarding Adults Competency Framework

A competency framework based on the National Occupational Standards for Health and Social Care and the National Competence Framework produced by Bournemouth University has been adopted by the Stockport Safeguarding Board. The framework identifies the knowledge and skills required by staff to carry out their specific roles identified within this policy and procedures. All training is delivered based on this framework.

For detail of available training go to: www.stockport.gov.uk/staffdevelopment

2.5.5 Nursing and Midwifery Council Code of Practice

The code is the foundation of good nursing and midwifery practice, and a key tool in safeguarding the health and wellbeing of the public. Please see the NMC website for info on safeguarding and training resources


2.5.6 Whistleblowing

Whistleblowing encourages and enables employees to raise serious concerns within their service rather than overlooking a problem or 'blowing the whistle' outside.

Employees are often the first to realise that there is something seriously wrong with the service. However, they may not express their concerns as they feel that speaking up would be disloyal to their colleagues or to their employer.

In order to encourage the raising of such concerns it is expected that all health and social care organisations have internal formal whistleblowing policies which are understood by all employees and volunteers.

Staff reporting concerns at work (whistleblowing) are entitled to protection under the Public Interest Disclosures Act 1998.

2.5.7 Risk Assessment

The Care Act 2014 requires all partners to implement robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under this policy and procedure.

Adults at risk have a right to take risks about their own lives. Where intervention is required under this policy and procedure, in considering any interventions practitioners should note adults at risk
who are in receipt of services under the Care Act 2014 or who are receiving services under the ‘Care Programme Approach’ will already have been assessed for services and any risk will have been taken into account as part of this assessment. Additional risk assessments will also have been undertaken by provider services. The adult protection process however may identify the need for further risk assessments and management plans to protect.

Disagreements about risk assessments and refusals of proposed interventions should be noted. Risk evaluation may change during the course of an intervention as risk levels reduce or increase. This may result in the need for further review to evaluate the concerns or changes.

A risk assessment (where appropriate) should be completed categorising the risk(s) presented and establishing the severity of possible injury, ill health or loss. The inquiry should consider the following categories:

- **High Risk** – The adult at risk is in immediate danger or at continuing risk of abuse which would include neglect.
- **Medium Risk** – The adult at risk is at risk because the potential harm is significant or the likelihood of abuse happening is high or both.
- **Low Risk** – The adult at risk may be at some risk of harm but it requires little or no action.

In the first instance practitioners should utilise their existing risk assessment procedures. (For risk assessment as part of adult protection procedures see section 4.15.3)

**2.5.8 Abuse by another Adult at Risk (sometimes known as service user on service user abuse)**

Service user on service user abuse is still abuse irrespective of the intention and/or the mental capacity of the service users involved.

Early intervention with service users who abuse others may be important in the protection of other adults at risk, preventing the continuation or escalation of abusive behaviour.

For further information in relation to responding to abuse in a service setting please see Levels of Harm Guidance and section 4.10.

**2.5.9 Abuse of Trust**

A relationship of trust is one in which one person is in a position of power or influence over the other person because of their work or the nature of their activity. There is a particular concern when abuse is caused by the actions or omissions of someone who is in a position of power or authority and who uses their position to the detriment of the health and well-being of a person at risk, who in many cases could be dependent on their care. There is always a power imbalance in a relationship of trust. Where the person who is alleged to have caused harm is in a position of trust with the adult at risk, they may be deterred from making a complaint or taking action out of a sense of loyalty, fear, of abandonment or other repercussions.

Where the person who is alleged to have caused the abuse or neglect has a relationship of trust with the adult at risk because they are a member of staff, a paid employee, a paid carer, a volunteer or a manager or proprietor of an establishment, the organisation will invoke its disciplinary procedures as well as taking action under the Safeguarding Adults policy and procedures. If a crime is suspected, reporting to the police should always be considered, and referral must be made to the Disclosure and Barring service (DBS) if they have been found to have harmed or put at risk of harm an adult at risk.
If the person who is alleged to have caused the abuse is a member of a recognised professional group the organisation will act under the relevant code of conduct for the profession as well as taking action under this policy and procedures. Where the person alleged to have caused the abuse or neglect is a volunteer or a member of a community group, adult social care services will work with the relevant group to take action under this policy and procedures.

Where the person alleged to have caused the abuse is a neighbour, a member of the public, a stranger or a person who deliberately targets vulnerable people, in many cases the policy and procedures will be used to ensure that the adult at risk receives the services and support that they may need. In all cases regard should be given to issues of consent, confidentiality and information sharing.

2.6 Partners in Safeguarding Adults

2.6.1 Adult Safeguarding and Quality Service

The primary function of Adult Safeguarding and Quality Service is to ensure that the Local Authority fulfils its responsibilities under Care Act 2014 and the Mental Capacity Act 2005. In the first instance this is to oversee the appropriate implementation of this policy and procedures across the Borough of Stockport both by Local Authority staff and all the partner agencies and services who are expected to comply by dint of their statutory, contractual or regulatory requirements.

The Adult Safeguarding and Quality Service has responsibility for the supporting the implementation of the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards and acts as the Supervisory Body for both Local Authority and NHS.

The Adult Safeguarding and Quality Service has the responsibility for the Investigation and co-ordination of complaints/contract compliance issues. It works closely with external regulators and has a pro-active role in quality monitoring of contracted providers. The Quality Assurance Officers make a significant contribution to the safeguarding process and should be kept informed of all investigations related to contracted providers.

The Adult Safeguarding and Quality Service provides advice and guidance on all operational matters where required as well as supporting the Workforce Development Service with the development and delivery of all relevant training. SAMCAS can be contacted at: ASQS@stockport.gov.uk

2.6.2 Stockport Police

The Police service in Stockport has been a co-signatory to the policy and procedures since its inception in 2002.

The Public Protection Investigation Unit (PPIU) covers matters relating to Child Protection, Domestic Violence and Vulnerable Adults.

There are dedicated officers for each part of the service and can be contacted at the following address: stockport.ppiu@gmp.police.uk

Or for secure email system users: stockport.ppiu@gmp.pnn.police.uk

In circumstances where immediate police involvement is required ring:

• 999 in an emergency
• 101 in a non-emergency

Further details and information is available at:

Go to:  http://www.gmp.police.uk/ for further information

Consultation with the police must be sought if:

• Non-accidental injuries are apparent or suspected
• Sexual offences are believed to have taken place
• Theft or misappropriation of funds is suspected
• The adult at risk wishes the matter to be referred to the police.

Early consultation with the police is also advisable in other cases because it allows the police to consider whether a criminal act has been committed and whether they need to become involved and avoids the possibility of undermining a police investigation. It may prevent the need for people to be interviewed twice. The police have a duty to obtain evidence of offences and a responsibility to investigate and interview an identified suspect. This process may not inevitably result in prosecution.

If the adult at risk does not wish the police to be involved, consideration should be given to the circumstances of the allegation. Consultation may be helpful even if the person does not want to make a formal complaint. Please note that there may be a wider public interest issue that lead to overruling the adult at risk.

The Police and Inquiry Officer should consider the need to use the ‘Achieving Best Evidence’ policy document. The policy addresses the needs of adult victims and witnesses only (aged 17 and over). It is primarily concerned with vulnerable victims and witnesses (Section 16 of the Youth Justice and Criminal Evidence Act 1999) who may or may not also be intimidated (Section 17). Witnesses who are solely regarded as intimidated may also have right to special measures to support them to give evidence in court in a less formal manner. Special measures were introduced by the Youth Justice and Criminal Evidence Act 1999 and are available both in the Crown Court and in the magistrates’ courts. These include the use of trained intermediaries to help with communication, screens and arrangements for evidence and cross-examination to be given by video link. It should be noted special measures do not currently apply to defendants.

The Police may take no further action because:

• On the basis of the information available it appears no criminal offence has been committed.
• On the basis of the information given the allegations do not warrant Police input.
• Consent is withheld by the adult at risk and there are no public interest issues.

2.6.3 Crown Prosecution Service (CPS)

The CPS is the principal public prosecuting authority for England and Wales and is headed by the Director of Public Prosecutions. The CPS has produced a policy on prosecuting crimes against older people which is equally applicable to adults at risk, who may also be vulnerable witnesses.

Support is available within the judicial system to support adults at risk to enable them to bring cases to court and to give best evidence. If a person has been the victim of abuse that is also a crime, their support needs can be identified by the police, the CPS and others who have contact with the adult at risk. Witness Care Units exist in all judicial areas and are run jointly by the CPS and the police.

The CPS has a key role to play in making sure that special measures are put in place to support vulnerable or intimidated witnesses to give their best evidence.
2.6.4 The Coroner

Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause, and deaths in custody, which must be reported to them.

With regard to the Mental Capacity Act 2005 Deprivation of Liberty Safeguarding 2009 the Managing Authority should inform the coroner’s office of the death of any person subject to authorised Deprivation of Liberty Safeguards.

Where the coroner is involved or is likely to become involved in a case which is subject to this policy and procedures please refer to sections 4.8.7 and 4.12.8.

2.6.5 The Probation Service

The Probation Service protects the public by working with offenders to reduce re-offending and harm. The Probation Service share information and work in partnership with other agencies including local authorities and health services, and contribute to local Multi Agency Public Protection Arrangements (MAPPA) to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public and previous victims from serious harm.

Although the focus of the Probation Service is on those who cause harm, they are also in a position to identify offenders who themselves are at risk from abuse and to take steps to reduce the risk to those offenders in line with the principals of this policy and procedures.

2.6.6 Stockport Adult Social Care

Stockport Adult Social Care shares the lead responsibility with Pennine Care NHS Foundation Trust for the coordination of all investigations related to the alleged abuse of an adult at risk where the abuse occurs within the boundaries of Stockport.

Social work team managers, assistant team managers, senior practitioners, qualified social workers and nurses within the Learning Disability Partnership all have designated responsibilities under this policy and procedures.

2.6.7 Pennine Care NHS Foundation Trust staff

Pennine Care NHS Foundation Trust shares the lead responsibility with Stockport Adult Social Care for the coordination of all investigations related to the alleged abuse of an adult at risk where the abuse occurs within the boundaries of Stockport. Team managers, deputy team mangers, qualified social workers and community mental health nurses and community occupational therapists all have designated responsibilities under this policy and procedure.

2.6.8 NHS Services in Stockport

The policy and procedures apply to all health services within Stockport. The NHS is accountable to patients for their safety and well-being through delivering high-quality care. This duty is underpinned by the NHS constitution that all providers of NHS services are legally obliged to take account of. Quality is defined as providing care that is effective and safe and which results in a positive patient experience. Some patients may be unable to uphold their rights and protect themselves from harm or abuse. They may have the greatest dependency and yet be unable to hold the service to account for the quality of care they receive. The NHS has particular responsibilities to ensure that those patients receive high-quality care and that their rights are upheld, including their right to be safe.
2.6.9 General Practitioners, Optometrists, Dentists and Pharmacists

All independent practitioners have a significant role in Safeguarding Adults. This includes:

- Making a referral to a Safeguarding Adults referral point should they suspect or know of abuse, in line with these procedures.
- Playing an active role in strategy discussions or meetings, case conferences and protection planning.

NHS England and the CCG should make sure that effective training and reporting systems are in place to support practitioners in this work.

2.6.10 The NHS Stockport Clinical Commissioning Group (CCG)

From 1st April 2013, NHS Stockport Clinical Commissioning Group formally took over the responsibility for local health services from Stockport Primary Care Trust (NHS Stockport).

The CCG has an important role in ensuring that the services they commission from are compliant with their own internal safeguarding responsibilities as well as with the local multi-agency procedures.

The Designated Nurse for Adult Safeguarding based at Regent House should be advised of any adult protection concern that relates to the provision of clinical care e.g. acute services, community services, care homes with nursing etc. The Designated Nurse may attend strategy meetings, case conferences and may have an investigatory role in certain aspect of any adult protection inquiry.

Go to:  [http://stockportccg.org/](http://stockportccg.org/) for further information

2.6.11 North West Ambulance Service NHS Trust (NWAS)

NWAS has its own system for raising safeguarding alerts where it is believed an adult has been harmed or is at risk of harm.

NWAS are often the first professionals on the scene and their actions and information recording can be crucial to subsequent inquiries and investigations and where appropriate the service should be requested to provide all relevant information.

Where concerns are raised that about the actions of the ambulance service, contact should be made with the Safeguarding lead for NWAS based in Bolton.

Go to:  [http://www.nwas.nhs.uk/](http://www.nwas.nhs.uk/) for further information

2.6.12 The Care Quality Commission (CQC)

The CQC regulates and inspects health and social care services including domiciliary services and protects the rights of people detained under the Mental Health Act 1983. It has a role in identifying situations that give rise to concern that a person using a regulated service is or has been at risk of harm, or may receive an allegation or a complaint about a service that could indicate potential risk of harm to an individual or individuals.

Where the CQC receives information about a possible Safeguarding Adults situation or issue, then that information must be immediately brought to the attention of the lead regulatory inspector for
the service, or the duty inspector. If, on a review of the information, there appears to be a Safeguarding Adults concern, the CQC should pass the information to the local authority through the locally determined referral point.

Following referral, the CQC may participate in any strategy discussions to consider on-going risk factors and the implications for the well-being for the people who use the service and contribute to the agreement of a protection plan.

The CQC must always be made aware of a Safeguarding Adults concern within a regulated service. If the concern is reported to the local authority, the local authority must notify the CQC even though the regulated service also has a duty to do so.

The CQC will be directly involved with a Safeguarding Adults process where:

- One or more registered people are directly implicated
- Urgent or complex regulatory action is indicated
- A form of enforcement action has been commenced or is under consideration in relation to the service involved.

The CQC would expect that registered providers and managers who are not implicated in the alleged abuse, people who use the service and/or their representatives are invited to attend meetings or to participate in the discussions.

Whether relevant CQC staff attend or not they must be sent copies of minutes of the agreed strategy. The regulatory inspector is responsible for ensuring that communication is established. If they have any concern about the proposed protection plan, they will discuss this with the responsible manager in the first instance.

Where the allegation suggests breaches of regulation and standards, the CQC may conduct enquiries or initiate a random inspection, in which case they will inform the relevant responsible manager. This activity may take place as well as other investigations being undertaken by another organisation. If the police are investigating, the CQC will coordinate their action with them.

The outcome of any assessment or investigation must also be shared with the CQC if it is related to a regulated service. The CQC have a role in ensuring adherence to any part of a Safeguarding Adults plan that relates to service compliance with regulation and standards.

Where the CQC have not undertaken any activity in relation to the initial concern, they should be notified of the outcome of the Safeguarding Adults process. If the allegation is substantiated and indicates a breach of regulation or standards, the CQC will consider whether any further regulatory activity is required and will inform the relevant responsible manager of their decision.

Go to: [http://www.cqc.org.uk/](http://www.cqc.org.uk/) for further information

### 2.6.13 Housing Organisations

Staffs employed by housing organisations are in a position to identify tenants who are adults at risk of abuse, neglect and exploitation. Supporting People housing has become a major provider of housing and support services for adults with a wide range of needs. The quality of their services is regulated through the Quality Assessment Framework, which includes standards that they must meet with regard to safeguarding adults from abuse. In addition to recognising the risks of abuse to adults to whom they provide accommodation and in many cases care, staff employed by housing organisations have an important part to play in establishing protection plans.

### 2.6.14 Court of Protection
The Court of Protection deals with decisions and orders affecting people who lack capacity. The court can make major decisions about health and welfare, as well as property and financial affairs. The court has powers to:

- Decide whether a person has capacity to make a particular decision for themselves make declarations, decisions or orders on financial and welfare matters affecting people who lack capacity to make such decisions.
- Appoint deputies to make decisions for people lacking capacity to make those decisions.
- Decide whether a lasting power of attorney or an enduring power of attorney is valid.
- Remove deputies or attorneys who fail to carry out their duties.

In most cases decisions about personal welfare will be able to be made legally by the appropriate decision maker without making an application to the court, as long as the decisions are made in accordance with the core principles set out in the Mental Capacity Act 2005. Any disagreements should be resolved informally. However, it may be necessary and desirable to make an application to the court in a safeguarding situation where there are:

- Particularly difficult decisions to be made.
- Disagreements that cannot be resolved by any other means.
- On-going decisions needed about the personal welfare of a person who lacks capacity to make such decisions for them self.
- Matters relating to property and/or financial issues to be resolved.
- Serious healthcare and treatment decisions, for example, withdrawal of artificial nutrition or hydration.
- Concerns that a person should be moved from a place where they are believed to be at risk.
- Concerns or a desire to place restrictions on contact with named individuals because of risk or where proposed Safeguarding Adults actions may amount to a deprivation of liberty.


2.6.15 Court appointed deputies

In a situation where a person does not have mental capacity and does not have anyone to act for them, the court can appoint a deputy to take decisions on welfare, healthcare and financial matters.

2.6.16 Office of the Public Guardian (OPG)

The OPG was established under the Mental Capacity Act to support the Public Guardian and to protect people lacking capacity by:

- Setting up and managing separate registers of lasting powers of attorney, of enduring powers of attorney and of court-appointed deputies.
- Supervising deputies.
- Sending Court of Protection visitors to visit people who lack capacity and also those for whom it has formal powers to act on their behalf.
- Receiving reports from attorneys acting under lasting powers of attorney and deputies.
- Providing reports to the Court of Protection.
- Dealing with complaints about the way in which attorneys or deputies carry out their duties.
2.6.17 Independent, Voluntary and Private Health and Social Care Providers

Employees in these organisations are in a unique position to identify adults at risk who are or may be experiencing abuse, neglect and exploitation. The majority of these services are regulated by the Care Quality Commission and are expected to comply with the Essential Standards for Quality and Safety which includes specific compliance with Safeguarding. For those providers not subject to regulation there is an equal expectation that they will cooperate fully with all measures developed to protect adults from abuse. This includes contributing to and implementing risk assessments and adult protection plans.

2.6.18 Personal Assistants

The introduction and development of Personal Budgets is increasingly leading to the establishment of a workforce which is independent of traditional services. This workforce should be familiar with the policy and procedures. All staff and volunteers from any service or setting who have contact with adults at risk have a responsibility to be aware of issues of abuse, neglect or exploitation. This includes personal assistants paid from direct payments or personal budgets or from the private funds of individuals.

2.7 Transitional Arrangements between Children and Adult Services

Whilst this policy and procedures relates to adults from the age of eighteen onward there will be many circumstances where the care needs of younger adults will continue beyond their eighteenth birthday. Additionally for some there will the continuation of the need for ongoing protection from abuse and risk of abuse.

Assessments of eligible needs at this stage should include issues of safeguarding and risk whilst maintaining their independence, well-being and choice. Care planning needs to ensure that the young adult’s safety is not put at risk through delays in providing the services they need as they make the transition to adult services.

Where somebody is eighteen or over and still receiving support from children services and a safeguarding issue is raised the matter should be dealt with via adult safeguarding arrangements irrespective of the young adult’s level of need.

Good practice includes:

- Having policies and procedures which support effective transition processes
- Acknowledging that the view of risk as a potential danger for a child is not necessarily the same for adult.
- Managing family expectations (being clear about the level of support and resources available).
- Taking time to get to know the young person and their family, especially if they have communication difficulties.
- Acknowledging the rights of adults to take more responsibility for their decisions.

2.8 Information Sharing
Early sharing of information is the key to an effective response where there are emerging concerns. The Care Act 2014 requires organisations to share information about individuals who may be at risk from abuse. It is important to identify an abusive situation as early as possible so that the individual can be protected. Withholding information may lead to abuse not being dealt with early enough. Confidentiality must never be confused with secrecy, nor should any professional assume someone else will pass on information which they think maybe critical to the safety and welling of the adult at risk. This policy and procedure requires all suspicions of abuse to be reported.

Information given to an individual member of staff, or organisation representative, belongs to the organisation not that member of staff. Personal information shared with a worker in the course of their employment is:

- Confidential to the employing organisation and can be shared within that organisation.
- Should only be used for the purposes for which it was intended.

Can be shared with another organisation either when:

- Permission is given by the person about whom the information is held.
- There is an overriding justification, statutory power or duty to share information without the person’s consent.

Investigating and responding to suspected abuse or neglect requires close cooperation 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.

This policy and procedures relies upon appropriate information sharing between partner agencies in relation to situations involving adults at risk who meet the criteria for Safeguarding Adults interventions.

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

2.8.1 Purpose of information sharing

The information exchanged will only be used for safeguarding adult purposes and where it meets these conditions:

- A criminal offence has taken place
- It may prevent crime
- The alleged victim is at risk of harm
- Staff, other service users, or the general public may be at risk of harm
- For early intervention and identification of abuse
- For investigations under safeguarding adult procedures.

2.8.2 Consent to the sharing of Information

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

Workers need to make sure that the adult at risk understands what will be recorded, what the information will be used for and with whom it might be shared. If the worker does not explain this,
they will not be able to give valid informed consent for information sharing to take place. The following information should be recorded clearly within their own organisation’s record:

- When consent to share information has been freely given.
- Why the information needs to be shared.
- What information the service user has consented to be shared.
- Who the service user has consented for the information to be passed to, and any limitations to this.
- That this has been explained to the service user and they understand the implications of giving consent to share their information.
- Any comments made by the service user in relation to the disclosure.

2.8.3 Overriding a refusal to share Information

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

The need to protect the individual or the wider public outweighs their rights to confidentiality. Decisions to share information about the adult at risk must be made by the organisation and not that member of staff acting on their own. This, however, should not cause unnecessary delay in the disclosure process. The worker must explain to the person why the disclosure needs to take place and to whom the information will be passed. This should generally be done unless it would increase the risks of harm.

The person’s decision to withhold consent to share information must be recorded, along with any further decisions to sharing information. Decisions to share without consent must make sure that it does not interfere with that person’s human rights.

2.8.4 Adult at Risk without the Mental Capacity to Consent

Where an adult at risk lacks the mental capacity to consent to sharing information, professionals are required to make ‘best interests’ decision which comply with the Mental Capacity Act Code of Practice. (See section 4.5. for more information)

2.8.5 Sharing information with carers, parents, family, partners etc.

When the adult at risk has the ‘mental capacity’ to make the decision, it is for them to decide what information is disclosed to their carers/parents/family/partners, and records should reflect this.

When the adult does not have the mental capacity, consideration should be given to when to share information with carers/parents of vulnerable adults. In addition, consideration must be given to the relationship between the carers/parents and the alleged abuser.

Clear decisions should be recorded about when and what to share, and about who is the most appropriate person to talk to the parent/carer etc. Generally some assessment should be made as to whether the sharing of certain information with a particular person or organisation is in the adult’s best interests.

2.8.6 Sharing Information with third parties about the (alleged) abuser
Under the Data Protection Act (1998), organisations and workers must ‘honestly and reasonably believe’ that the sharing of information is necessary to protect a vulnerable adult or the wider public and should consider the following issues:

- How strong is the belief in the truth of the particular allegation? The greater the conviction that the allegation is true, the more compelling the need for disclosure.
- What is the interest of the third party in receiving the information? The greater the legitimacy of the interest in the third party in having the information, the more important need to disclose.
- What is the degree of risk posed by the individual if disclosure is not made?
- Decisions about who needs to know and what needs to be known should be taken on a case-by-case basis. It is vital there is a balancing exercise undertaken weighing the serious consequences of disclosure against risks to vulnerable adult.
- This decision will be made as part of the safeguarding process, where it will be determined who will contact and speak to the alleged abuser and how this will be managed.

2.8.7 Disclosures to other organisations outside of the Safeguarding Process

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

Caution should be exercised before making any such disclosure: it should be seen as an exceptional measure. The following check list may be of assistance:

- The alleged perpetrator presents a risk of serious harm to the adult at risk, or to those for whom the recipient of the information has responsibility.
- There is no other practical, less intrusive means of protecting the adult at risk, and failure to disclose would put them in danger. Information which is necessary to prevent harm should be disclosed, this will rarely be all the information available.
- The risk to the alleged perpetrator should be considered however it should not outweigh the potential risk to others if a disclosure was not made. The alleged perpetrator retains his rights and consideration must be given to whether those rights are endangered as a consequence of the disclosure.
- The disclosure is to the right person and that they understand the confidential and sensitive nature of the information they have received. The information should not be disclosed by the recipient third party without the express permission of the original disclosing organisation.
- Consider consulting the alleged perpetrator about the proposed disclosure. This should be done in all cases, unless to do so would not be safe or appropriate. If it is possible and appropriate to obtain the individual’s consent, then a number of potential objections to the disclosure are overcome.

2.8.8 Access and Security

Access to personal information must be adequately protected from unauthorised or inappropriate access. Parties to this policy and procedure must implement and maintain appropriate security measures to protect confidentiality, integrity and availability of personal information. Adopted
security measures must be effectively communicated to all staff and system users, detailing individual roles and responsibilities.

2.8.9 Confidentiality

All organisations and staff involved in the commissioning or provision of health or social cares have a duty to maintain the confidentiality of personal information.

(See section 4.6. for further information)

2.9 Abuse in Domestic Relationships

2.9.1 Referrals to the Multi-agency Risk Assessment Conference (MARAC)

The MARAC is a multi-agency process where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, children and adults safeguarding, housing practitioners, substance misuse services, independent domestic violence advisers (IDVAs) and other specialists from statutory and voluntary sectors.

The aims of the MARAC are:

- To share information to increase the safety, health and wellbeing of victims – adults and their children;
- To determine whether the perpetrator poses a significant risk to any particular individual or to the general community;
- To construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- To reduce repeat victimisation;
- To improve agency accountability;
- To improve support for staff involved in high-risk DV cases.

After sharing all relevant information that they have about an adult at risk, the representatives discuss options for increasing the safety of the adult at risk and form a coordinated action plan. The MARAC will also discuss the risks posed to children and how to manage the person alleged to be causing the harm. At the heart of a MARAC is a working assumption that no single agency or individual can see the complete picture of the life of a person at risk, but all may have insights that are crucial to their safety, as part of the coordinated community response to domestic violence.

Relevant forms, agency tool kits and further information about the MARAC can be obtained through: http://www.stockportdaf.org.uk/marac.html

If a Safeguarding referral indicates there could be concerns that the adult at risk is a victim of domestic violence, stalking or honour-based violence and this is confirmed by subsequent information, a decision must be taken at the strategy meeting or case conference whether or not to refer to the MARAC. In most cases this would be decided by the responsible manager.

2.10 The Channel Process – (Prevention of Violent Extremism)

The governments counter terrorism strategy (CONTEST), has four strands to it:

- Pursue
- Prevent
The Prevent Agenda includes the Channel Project, which is a pan Greater Manchester initiative which sets out to identify and support through a multi-agency process, those adults at risk as defined under this policy, who may be susceptible to exploitation into violent extremism by radicalisers across the political spectrum. Additionally, adults at risk may be spontaneously drawn towards the messages of radicalism as a result their personal circumstances.

For further information including how to refer see ‘Related Documents’

2.11 Honour Based Violence

Honour-based violence is a crime, and referring to the police should always be considered. It has or may have been committed when families feel that dishonour has been brought to the family. Women are predominantly (but not exclusively) the victims and the violence is often committed with a degree of collusion from family members and/or the community. Some victims will contact the police or other organisations themselves, but some may be so isolated and controlled that they are unable to do this. Alerts that may indicate honour-based violence may include issues of domestic violence, concerns about forced marriage, enforced house arrest and missing persons. If a concern is raised through a Safeguarding Adults referral, and there is a suspicion that the adult is the victim of honour-based violence, there should be early consultation with the specialist police officers in the Public Protection Investigation Unit (PPIU).

For further information go to: 

http://www.cps.gov.uk/legal/h_to_k/honour_based_violence_and_forced_marriage/

2.12 Forced Marriage

Forced marriage is a term used to describe a marriage in which one or both of the parties are married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties consent to the assistance of their parents or a third party in identifying a spouse.

If a concern is raised through a Safeguarding Adults referral, and there is a suspicion that the adult is the victim of forced marriage, there should be early consultation with the specialist police officers in the Public Protection Investigation Unit (PPIU)

HM Government guidelines can be found at:


2.13 Female Genital Mutilation (FGM)

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life.
The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of five and eight and therefore girls within that age bracket are at a higher risk.

FGM is illegal in the UK.

Serious Crimes Act 2015 section 72 introduces the new offence of failing to protect a girl from FGM. This will mean that if an offence of FGM is committed against a girl under the age of 16, each person who has responsibility for the girl at the time FGM occurred will be liable under this new offence. The maximum penalty for the new offence is seven years’ imprisonment or a fine or both.

Section 74. Duty to notify police of female genital mutilation

(1) A person who works in a regulated profession in England and Wales must make a notification under this section (an “FGM notification”) if, in the course of his or her work in the profession, the person discovers that an act of female genital mutilation appears to have been carried out on a girl who is aged under 18.

Part 3 - Procedures for Responding to and Reporting Allegations, Concerns or Suspicions of Adult Abuse

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3.14 The Prevention of Abuse and Promotion of Standards for a Safer Service
3.1 Introduction

This section is intended as guidance for all external organisations and individuals whether in a paid or unpaid capacity who have a reasonable belief that an adult may be being harmed or at risk of harm.

It sets out the actions to be taken immediately in order to safeguard or prevent further harm and clarifies the process for referring the adult at risk to the Local Authority for further action under this policy and procedure.

The precise actions necessary in any individual case will vary according to the circumstances and therefore stages may overlap depending on how the investigation develops.

3.1.1 Duty to Report

Once a suspicion, disclosure or allegation of abuse of an adult at risk, has been made, the receiver of this information, known as the alerter has a duty to report their concerns immediately once a suspicion, disclosure or allegation of abuse of an adult at risk, has been made, the receiver of this information, known as the alerter has a duty to report their concerns immediately to the designated Safeguarding referrer for their organisation.

3.1.2 Provider Managers of care provision

Where an organisation is aware abuse has taken place they have a duty to correct this and protect the adult at risk from harm and inform the local authority, CQC and CCG where appropriate

3.1.3 Duty of candour

The Care Act requires providers/commissioners to have an open culture around safeguarding, this will ensure best outcome for the adult at risk and will provide key learning for improvements in practice.

Please see the Harm Levels Guidance and associated documents for threshold information i.e. a single agency response to an alert.

Harm Level 3 investigation, as identified by the commissioned provider of care, will be carried out under section 42 of the Care Act 2014 as the Local Authority causing others to make safeguarding inquires.

Level 3, 4 and 5 must be alerted to the Adult Social Care and Care Quality Commission.

All level 3 investigations will be scrutinised by a multi-agency panel for quality control and audit purposes and multiagency information sharing.

3.2 The Six Stages of the Multi Agency Investigation Process

1. Alert Process (initial through to formal alert )
2. Referral (decision to progress under the multi-agency procedures)
3. Strategy discussion or meeting
4. Investigation (Section 42 Enquiry under the Care Act 2014)
5. Case Conference and Protection Plan
6. Review & Case Closure

Stages 2 to 6 are briefly explained below. (For more detailed information see section 4.13 onwards)

3.2.1 Stage one - Raising the alert

Anyone should consider themselves a potential alerter.

3.2.2 An alert form a member of the public

(Including family members/unpaid carers)
If you are a member of the general public concerned about abuse of an adult please consider the following:

- Is the adult in immediate danger or at risk of harm?
- What is the nature of your concern?
- Is the adult able to give their consent to you before you raise your concerns with the relevant person or organisation?

3.2.3 If you are the victim of abuse

If you are being abused or neglected you will know that it may be hard to speak up and get help. You may be scared about what the person harming you may do if they find out you have spoken out. You may feel that the abuse is your fault. These are normal reactions to being abused.

- Remember that you deserve to live your life free from fear.
- Remember that people have managed to get out of abusive situations.
- Remember your abuser may need help.

3.2.4 Who should you contact?

Whether you are raising an alert on behalf of yourself or on behalf of another:

- You should speak with any of the agencies known to be involved in yours or the persons care or telephone the Stockport Direct Contact Centre:
  
  **Telephone:** 0161 217 6029
  **Minicom:** 0161 217 6024
  **Out of Hours:** 0161 718 2118

Please contact the police immediately if you think a crime has been committed.

- In an emergency telephone 999
- For all other matters telephone 101
- Stockport Police 0161 8725050
3.3 Health, Social Care and Related Providers as Alerters

It is the responsibility of any individual or organisation who is affiliated to this policy and procedures to take action if they suspect abuse of an adult at risk. Once a suspicion, disclosure or allegation of abuse of an adult at risk, has been made, the receiver of this information, known as the alerter has a duty to report their concerns immediately. This should be to their line manager or volunteer organiser, with responsibility for the service. (If the line manager or volunteer organiser is the alleged or suspected abuser, the matter should be reported to a more senior manager within the organisation (see your own internal Whistle Blowing guidance).

If you are unsure who to speak to or wish to raise an alert please contact the Stockport Direct Contact Centre on 0161 217 6029.

For general advice during office hours you can also contact the Adult Safeguarding and Quality Service on 0161 474 4600

3.3.1 Action for Alerters

Additionally it is the responsibility of the alerter or their line manager, either before or immediately after raising the alert to take the following steps when they first become aware of an abusive situation.

**SPIRE**
- Safe
- Preserve
- Inform
- Record
- Encourage

The following procedures apply to all organisations and their personnel who are engaged in any type of provision to adults at risk regardless of whether this is on a statutory, voluntary, independent or private arrangement.

**Step 1 – Safe**: Make sure the person is safe – this may mean calling emergency services if the person is in danger or requires medical treatment.

**Step 2 - Preserve**: Any evidence (if applicable) should be preserved e.g. DO NOT disturb or destroy any articles that could be used as evidence, **do not wash** the person unless this is associated with any first aid treatment that may be necessary. Similarly any clothing, bedding etc. should not be disturbed or washed.

**Step 3 – Inform**: Your line manager, if you have not already done so, or someone more senior if the allegation is against your manager. If there is evidence of a criminal act e.g. a physical assault, theft, neglect or sexual assault the manager should contact the police being careful to record and preserve evidence.

**Step 4 – Record**: The adult’s views and wishes, any conversations or descriptions in the person’s own words, date time and sign the record. If appropriate complete a body map recording any injuries to the individual.
Step 5 – Encourage: Reassure the adult at risk that they have done the right thing and that you are taking their concerns seriously. Advise them that you will be informing your line manager immediately.

3.3.2 Action for Alerter Managers

Three Steps the Line Manager should take when they are made aware of an abuse situation:

ACE
Address
Clarify
Escalate

Where the alleged abuse has occurred in a care setting the first responsibility to act must lie with the employing organisation as the provider of the service. The focus should be on prompting the well-being of the adult at risk once the allegation or suspicion has been raised with the line manager with responsibility for the organisation, s/he must decide without delay the most appropriate course of action.

It is the line manager’s responsibility to consider the Harm Levels Guidance when deciding if the Adult at Risk falls within this policy & procedure i.e. meets the definition of an adult at risk as defined in the Care Act and make an alert to the Stockport Council Adult Contact Centre or the Pennine Care Access Team. A multi-agency response will be required for harm levels 4 and 5 Guidance and a single agency response for level 3.

For further information in relation to responding to abuse in a service setting please see Levels of Harm - Guidance

It is the responsibility of the line manager to:

Step 1 – Address the immediate needs of the situation:

- On receipt of any report or concern about possible abuse, ensure the immediate safety of the adult at risk or others.
- Ensure that forensic evidence is preserved.
- Contact the police if you think a crime may have been committed.
- Ensure accurate records of the allegation or suspicion to be obtained and recorded appropriately. These should be as contemporaneous as possible.
- Obtain the view of the adult at risk in respect of both their understanding of the situation and the action they would like taken and their desired outcomes. Managers must be mindful that if the adult at risk does not consent to an alert under this policy, this may be overridden where there are implications for other adults at risk.
- Establish if an independent advocate is required and notify the Stockport Local Authority of this need immediately.
- Ensure a member of staff is allocated to attend to the needs of the alleged perpetrator if they are also an adult at risk.
- Contact the Care Quality Commission (CQC) if the person is in a regulated service.
Step 2 - Clarify

- Establish the facts and gather further information to inform the alert process.
- Deal with any Human Resources (personnel) issues i.e. suspension. If the alleged perpetrator is a member of staff refer to your own HR policy and procedure.
- Establish information sharing and confidentiality issues.
- Record further actions taken following the disclosure. Complete a body map if appropriate.
- If you are the manager in regulated service complete the necessary regulation requirements and inform CQC e.g. form 19 for abuse.
- Establish the views of the alleged victim and ascertain the desired outcome of any investigation.

Step 3 – Escalate to formal safeguarding alert (Section 42 Care Act 2014)

Following steps one and two and where the Line manager is satisfied the situation exceeds level two of the Harm Levels guidance a formal safeguarding alert must be made immediately.

To make an alert telephone 0161 217 6029 Stockport Adult Social Care Contact Centre (Office hours 8.30am-5pm Monday to Thursday, Friday 8.30am - 4.30pm)

Out of Hours Service (Adult Social Care) (operates when day offices are closed) telephone 0161 718 2118

*Where criminal activity is suspected, the police must be contacted.

3.4 Host Local Authority Responsibility

You should contact Stockport Adult Social Care if the person is resident in Stockport even if the persons care is paid for by another authority. If this is the case you should also contact the ‘funding’ authority.

3.5 Information Adult Social Care/Police/CQC will need from you when making a Safeguarding Alert

- Personal details of adult at risk (name, address, date of birth, NHS number, ethnicity, current whereabouts, language spoken).
- Who you are and why you are involved.
- What happened, when and where?
- Details of alleged abuser(s) (name, address, date of birth) and relationship to adult(s) at risk.
- Are there any other people at risk including any children?
- Details of any other agencies involved.
- Is the adult at risk aware of the referral and have they consented?
- Remember – do not start investigating the incident(s) yourself until a strategy discussion.
3.6 Timescales

3.6.1 Alert stage:

Managers should respond to all alerts on the same day they are brought to their attention by making contact with Stockport Adult Social Care Contact Centre or Stockport Out of Hours Service outside of office hours.

When an alert is received by Stockport Adult Social Care Contact Centre, if appropriate it is passed on the same day to the relevant Social Work Team, Out of Hours Team or Pennine Care Access and Crisis Team or Adult Safeguarding and Quality Service.

3.6.2 Referral stage:

Following receipt of the alert the Adult Social Care Responsible Manager will make a decision on the same working day whether or not immediate action is required and if it requires investigation under this policy and procedure – if the alert does not meet the criteria for an investigation, the alerter should be notified of the decision.

3.6.3 Strategy Stage:

Strategy discussion/meeting– this is a planning meeting and should happen as soon as possible within five working days of receipt of the alert.

3.6.4 Inquiry/investigation stage:

Time scale for investigation is 25 days from receipt of the alert to allow time for the collation of investigation information prior to the case conference.

3.6.5 Case Conference and Protection Plan stage:

Case Conference meeting. This meeting is to discuss the investigation findings and will happen within 28 days (four weeks) from receipt of the alert to address the outcome of the investigation. If this time scale is not possible the reasons for any delay must be clearly reordered.

3.6.6 Review Stage:

Review meeting will be scheduled at the case conferences and may be required where the implementation of an adult protection plan requires monitoring (outside of the care management/care programme process)

3.7 Key issues affecting the decision to make an alert

A range of factors will be taken into account when deciding whether a case warrants further action to be taken under this policy and procedures, and include:

- Historical abuse – a decision will be taken as to whether this can be investigated under safeguarding, a general rule should be that cases are investigated as soon after the incident happens as possible; as vital evidence/witnesses may be lost if a period of time elapses.
Individuals may disclose historical abuse to those involved in their care. In such cases the responsible manager will make a decision whether to investigate under the policy and procedure or address the disclosure with alternative appropriate social work interventions. The decision will involve the responsible manager weighing up the benefits of a safeguarding investigation and the implications of its outcome.

- Historical childhood abuse will not be investigated under this policy and procedures. Please support any adult at risk disclosing such abuse to access the appropriate channels e.g. Police and/or GP.
- The level of vulnerability and the risk to others in the same or similar situation.
- The views and informed opinions of staff in the partner agencies.
- The nature and extent of the alleged abuse.
- The impact of the abuse on the individual.
- The risk of repeated incidents or the risk of an escalation in the seriousness of incident.
- Has the adult at risks Human Rights been breached:
  Article 2 - Right to life
  Article 3 - Prohibition of torture, and inhuman and degrading treatment.
  Article 5 - Right to liberty and security of person.

3.8 Provider Managers/ Single Agency Response.

Where the line manager reaches the clear conclusion that the adult at risk incident does not need to be investigated under this policy and procedure (i.e. multi agency investigation), all subsequent action must comply with that set out in the Harm Levels Guidance. This will ensure the incident and the actions taken are appropriately recorded and/or investigated.

For further information in relation to responding to abuse in a service setting please see Levels of Harm Guidance [http://www.stockport.gov.uk/2013/2996/1201778/harmlevelsguidance](http://www.stockport.gov.uk/2013/2996/1201778/harmlevelsguidance)

Please note any level 3 investigation report must be submitted within 28 days of the alert being raised.

3.9 Responsibility of Providers Managers in Adult Protection Process

The general assumption is that registered providers and managers are judged to be fit and where they are not implicated in the alleged abuse, they will be pro-actively involved as partners in addressing the alleged abuse.

The registered manager of the service (where not implicated) will be expected to take the lead regarding any internal investigation process.

The registered manager/senior manager will be required to comment on the mental capacity of the alleged victim and/or perpetrators.

The registered manager/senior manager must ensure an independent advocate is available to support the adult at risk where required as defined under the Care Act 2014.

It is the responsibility of the registered manager/senior manager to inform CQC and report on any RIDDOR issues.
The registered managers/senior manager will need to provide any relevant additional information regarding the alleged victim and/or perpetrators.

It is the responsibility of the registered manager/senior manager to take the lead in interviewing all staff who may be relevant to the investigation. This may include those implicated, witnesses or those with particular knowledge of the victim and/or perpetrator.

It is the responsibility of the registered manager/senior manager to provide a formal report for consideration at case conference.

It is the responsibility of the registered manager/senior manager to engage in all six stages of the adult protection procedures including attending the strategy, case conference and review meetings.

It is the responsibility of the registered manager/senior manager to refer to the DBS where appropriate.

3.10 Staff Care

Involvement in adult protection work may be stressful for staff who need to empathise with victims and carers, confront abuse issues, resolve conflict and establish support and protection. It is important that the impact on staff is recognised and that they have appropriate opportunities for support through management or clinical supervision. If necessary, it should be possible to offer access to confidential independent counselling.

Where there is likely to be a risk to the personal safety of staff, managers must ensure that appropriate arrangements are made and recorded in line with the organisation’s ‘Violence to Staff’ policy.

Staff who report allegations or suspicions of abuse should receive acknowledgement and support, especially where the abuse involves colleagues, and within the bounds of confidentiality, should be offered feedback on how their concern has been dealt with. Witnesses who are workers or volunteers may be permitted support or representation in accordance with their agency’s procedures. Witnesses, who are relatives or unpaid carers, friends etc. may invite a friend or advocate on the basis such people are neither witnesses nor form part of an inquiry. In criminal investigations, witnesses may be entitled to legal representation.

3.11 What to do if the person does not live in Stockport but is funded by Stockport LA/CCG

Where a person lives outside Stockport but Stockport retains responsibility for their service:

(a) The procedures, which operate within the authority where the abuse occurred, will apply.

(b) Adult Social Care Stockport and CQC and the host authority, must be notified of any incidents of abuse/assault.

(c) The relevant Stockport Social Work Team may need to allocate a Social Worker to support the abused person.

3.12 What to do if the person lives in Stockport but is funded by another LA/CCG
If however, the person lives in Stockport but is funded by another authority, as the host authority Stockport Council will Co-ordinate and chair any strategy/other meetings. A decision about who is best placed to investigate such cases will be taken at the initial strategy meeting.

For further information on out of area safeguarding arrangements go to: [http://adass.org.uk/images/stories/Policy%20Networks/Safeguarding_Adults/Key_Documents/ADAS_S_GuidanceInterAuthoritySafeguardingArrangementsDec12.pdf](http://adass.org.uk/images/stories/Policy%20Networks/Safeguarding_Adults/Key_Documents/ADAS_S_GuidanceInterAuthoritySafeguardingArrangementsDec12.pdf)

### 3.13 What to do if the person does not fit the definition of an Adult at Risk

It is recognised that not all circumstances involving adults will fall within the definition that invokes this policy and procedure (i.e. Adult at risk has known care and support needs). Some adults however, may still be at risk from harm and/or abuse from others because of other factors such as lifestyle choices, homelessness, exploitation, drug and alcohol misuse etc.

The decision to carry out a safeguarding enquiry does not depend on the person’s eligibility, but should be taken wherever there is reasonable cause to think that the person is experiencing, or is at risk of, abuse or neglect and because of their care need are not able to protect themselves from the abuse or neglect. Where this is the case, a the Local Authority must carry out (or request others to carry out) whatever enquiries it thinks are necessary in order to decide whether any further action is necessary.

As such we have a duty to consider anyone being abused and their desired outcomes regarding the abuse, ensuring that an appropriate outcome is achieved. This may result in a needs assessment and subsequent provision of services under section 18 or 19 of the Care Act or the provision of preventative services under section 20 or information and advice under section 4 of the Care Act, such as a referral to Multi Agency Adult At Risk System (MAARS) Targeted Prevention Alliance (TPA).

### 3.14 The Prevention of Abuse and Promotion of Standards for a Safer Service

To ensure a safer service is created all agencies/organisations will need to develop their own guidelines, which will address the following standards:

- Rigorous Recruitment and Selection which will facilitate effective intervention to recruit the best staff, and prevent the recruitment of abusers. Disclosure and Barring Schemes check will also form part of this.
- Services that are person centred, promote well-being, reflective, pro-active and open to question, observation and change.
- Safeguarding adults at risk be is embedded in the culture of all organisations.
- The Adult at Risks wishes, feelings and desired outcomes are central to all action taken.
- Investigations of allegations of abuse are immediate, consistent and transparent.
- Disciplinary Procedures are compatible with the responsibility to protect adults at risk.
- Procedures exist for reporting to the police when allegations of criminal behaviour are made against staff.
• Internal guideline which relate to this policy and procedure for adult safeguarding/protection.

• Commissioners and purchasers of services will ensure that adherence to the standards of a safer service are part of the contract.

• A ‘whistle blowing policy’ to support and protect staff making complaints, allegations or expressing concerns about abuse.

• Operational guidelines ensuring best evidence based practice to deal with:
  
  (i) Challenging behaviour
  (ii) Personal and intimate care
  (iii) Physical intervention (control & restraint)
  (iv) Sexuality
  (v) Medication
  (vi) Handling of adult at risk money
  (vii) Risk Assessment and Management

• A code of conduct that sets unambiguous boundaries for staff/service user relationships and states that a sexual relationship that develops between a service user and a member of staff will always be regarded as abuse.

• A policy for dealing with staff who behave in a way in their personal life that may have an effect on their ability to work with adults who are vulnerable.

• Ensuring that users, carers and the public are aware of the Policy, Procedure and Guidance through a variety of different communication mechanisms.

• All staff receive on-going personal training and development and are regularly supervised.

• All staff to receive specific training in relation to adult safeguarding/protection.
Part 4 – Operational Procedures for Investigating Adult Abuse

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4.1 Introduction

Safeguarding Adults at risk is everybody’s business. The Care Act 2014 places a duty on all relevant partners to ensure that all safeguarding work is underpinned by the principles of the Care Act,

Empowerment
Prevention
Proportionality
Protection
Partnership
Accountability

There is also the requirement for all partners to co-operate with each other and the Local authority (as lead agency as defined in the Care Act). This will ensure clarity of roles and responsibilities, a timely and effective response to and prevention of abuse and or neglect of adult at risk.

The Care Act 2014 places a duty on Local Authorities to make safeguarding enquires or cause others to do so if they reasonably suspect an adult,

• has needs for care and support (whether or not the Local Authority is meeting any of these needs) and;
• is experiencing, or at risk of abuse or neglect; and
• as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect

The Care Quality commission (CQC) is the regulatory body responsible for the inspection and regulation of health and social care services. Their regulatory role includes all aspects of the adult protection process.

It is the role of all regulated and inspected providers to engage appropriately with any work identified as part of the adult protection process.

4.2 Statement of Risk and Staff Support

Risk in life is unavoidable. Adults at risk should be supported to engage in the type of risk related behaviours all adults are entitled to take. However a balance is required to ensure unacceptable risk taking does not outweigh our legal duty of care to intervene to protect those we work with.

Risk assessments are essential tools for professionals to use in determining risk. Any assessment of risk should include consideration of all factors which may contribute to abuse. Staff should adhere to their own policy and procedures relating to Risk Management and Assessment, and record on the relevant documentation.
4.3 Non Engagement of an Adult at Risk in Adult Protection (Including those who Self-Neglect.)

Not all adults at risk will want to engage with the adult protection process. There may also be situations where professional intervention may be restricted or prohibited due to the limitations of our statutory powers. This may result in some cases where adults who appear to be vulnerable are left at risk in unsafe situations. Even when a high-risk situation has been identified, staff may often find that they have no basis to intervene positively because the adult and or carer have exercised their right and have the mental capacity to refuse all help and intervention.

Where it has been established that the adult at risk has mental capacity and does not consent to an investigation staff should be mindful that the adult at risk may be subject to threats, intimidation or coercion and should be offered the opportunity to discuss their decision in a safe environment.

In most cases of high risk self-neglect situations a multi-agency strategy meeting will be required. The purpose of which will be to share information, explore mental capacity issues and identify and acknowledge risks with colleagues from other agencies.

The adult at risk will be central to any further exploration of the risks with a view to acknowledging risk and/or reducing potential harm. The adult at risk will be supported to identify their desired outcomes and provided with copy of the risk assessment.

Additionally it is recognised that where there are justified suspicions of abuse occurring but no real evidence is available this can cause distress for the staff involved who may require on-going support to enable them to continue to operate within an abusive situation.

4.4 Staff Support with regard to Adult at Risk Non Engagement

In difficult situations such as those described above staff are entitled to expect and receive management support. Every effort should still be made through multi-disciplinary working to protect the adult at risk as far is possible and all decisions taken in these cases should be fully recorded.

4.5 Capacity and Consent

All people should be supported to live as independently as possible, making their own decisions about their own lives, thus requiring the minimum necessary intervention from the state.

In every situation it will be assumed that a person can make their own decisions unless it is evident that they are unable to do so. This principle of assumption of capacity is enshrined in the Mental Capacity Act 2005 and is the first of the five key principles.

The Mental Capacity Act 2005 is statutory and demands full adherence from all involved in the adult safeguarding/protection process.

The Mental Capacity Act 2005 sets out a statutory definition of capacity:

“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 a matter because of an impairment of, or a disturbance in the functioning of the mind or brain”.

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**Capacity Assessments** should follow the two stage test for capacity set out in the Mental Capacity Act 2005 and the Code of practice Chapter 4

Therefore a person lacks capacity if:

- they have an impairment or disturbance (for example, a disability condition or trauma) that affects the way their mind or brain works,

and

- the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

To reiterate this means that the issue of capacity is **time** and **decision** specific. It is no longer acceptable to class someone as 'not having capacity'.

In an adult protection investigation the responsible manager must be satisfied that the capacity of the adult at risk has been established and whether or not the adult at risk has consented to the adult protection investigation.

Where it is established that the adult at risk does not have capacity to consent a best interest decision must be made and documented before the adult protection investigation proceeds. This action could be addressed at the point of strategy meeting if the issue of capacity has not been established pre-strategy meeting.

There may be more than one decision relating to the adult at risk in relation to the adult protection investigation and each decision should be addressed on an individual basis i.e. the adult at risk may not have the capacity to make a decision about where they live and the care and treatment they require but they may be able to consent to being interviewed about an alleged abuse incident.

In circumstances where it is assessed the an adult at risk lacks the capacity to make a decision about the adult protection investigation the responsible manager should be satisfied that in assessing the individual every reasonable effort has been made to assist their understanding of the situation and their wishes have been communicated to the investigation. This may require arranging an advocate or an interpreter where necessary. It is important to start from the assumption that the adult at risk is trying to find some way of communicating their wishes, rather than that they cannot do so.

In any circumstance where an adult at risk is assessed as not having the mental capacity to consent to the adult protection investigation, consideration must be given to the involvement of an Independent Mental Capacity Advocate (IMCA).

**4.6 Confidentiality**

All organisations and staff involved in the commissioning or provision of health or social care have a common law duty to maintain confidentiality with regard to personal information.

In most circumstances, information given in confidence should only be used for the purposes that the person has consented to. Information is considered to be confidential where it is reasonable to assume that the person believed this to be so. It is accepted that this applies equally to personal information about service users and staff.

It is accepted, however, that the sharing of information for use within a care/medical team about an adult at risk can be implied without necessarily having been obtained explicitly.

All agencies working to this policy and procedures are working under the duties as set out in the Care Act 2104 and are therefore committed to sharing information to protect adults at risk from abuse. Public bodies still however need to adhere to the principles of Data Protection and those set out in the Caldicott review 2013 and will only share information on a **need to know** basis. Where
information is shared this should be the minimum necessary that is adequate and appropriate for the purpose needed.

If an adult at risk withholds consent to the sharing of information, this may only be overridden where it can be justified to do so in the public interest. This may arise, for example, where there is a concern that other adults at risk and/or children may be at risk or where it is considered that the adult at risk does not have the mental capacity to make decisions regarding sharing information or criminal activity is suspected.

Where the adult at risk declines to consent to the sharing of information regarding what has happened to them, the decision to share this information remains with the appropriate agency. The adult at risk should be informed by the appropriate agency of the reasons why they have decided to share the information, which should be recorded in full and on the appropriate documentation.

Where there is an overriding public interest that would justify sharing of information the person sharing the information may need to consult the appropriate Caldicott Guardian for further information please see


4.7 Ownership of Information

All adult protection meeting minutes should contain the following disclaimer:

Please note that these minutes are private and confidential and remain the property of Stockport Council. These minutes are not to be disclosed to any other parties, used or redistributed without explicit consent from the Responsible Manager (Chair).

4.8 Sharing of Investigation Information

4.8.1 Check List

Decisions about sharing information need to be taken on a case by case basis. Therefore before you share information you need to ask yourself the following questions:

(a) Do I have the permission of the adult at risk to disclose personal information?
   If not:
   (b) Do I have the legal authority to disclose this information?
   (c) Is a Best Interest Decision required under the Mental Capacity Act 2005?
   (d) Is there a duty to protect the wider public interest, are other people at risk?
   (e) Am I proposing to share information with due regard to both common and statute law?
   (f) Do I have the correct level of seniority to disclose this information?
   (g) Have I completed all the relevant documentation/recording in relation to the above considerations?
Where there is uncertainty about withholding or sharing information, guidance should be sought from a senior manager and/or Legal Services or Adviser/ Data Protection and Access to Records Coordinator or Caldicott Guardian.

4.8.2 Sharing of Adult Protection Meeting Minutes/information

Please refer to ‘The Responsible Manager and Administrative Support Service Guidance’ in related documents.

Family members, solicitors and/or friends of the adult at risk do not have an automatic legal entitlement to all safeguarding records, investigation information and minutes.

Any information shared must be with the consent of the adult at risk. If the adult at risk lacks the mental capacity to consent a best interest decision will be required. Any information shared must be on a need to know basis and include an assessment of the validity of the request. If unsure speak to the relevant Data Protection and Access to Records Coordinator, before making any disclosure.

4.8.3 Sharing of Strategy Meeting Minutes

Minutes and additional information such as statements or other evidence discussed at the strategy meeting, in most cases should not be shared outside of the invitees or attendees of the strategy meeting.

There is a distinction between information regarding allegations of abuse and other types of information held by Adult Social Care/Pennine Care NHS Foundation Trust such as care management information. This distinction relates to the sensitivity of the information for both the alleged abused and the alleged abuser.

In addition the professional methods of investigation employed by the investigators are not appropriate to share with adults at risk or third parties.

Strategy meetings are professional meetings which will include detailed discussions regarding the investigation process. Therefore the minutes should not be shared with the alleged victim and/or their representatives or following a third party request.

Exceptions to the above:

- Court request (Criminal/Coroner/Court of Protection)
- Request for information by Disclosure and Barring Service
- A Subject Access Request under the Data Protection Act

Following such a request please contact the responsible manager for the specific investigation who can liaise with the Data Protection and Access to Records Coordinator telephone: **0161 474 4299**.

4.8.4 Sharing of Case Conference minutes

All attendees and invitees will receive a copy of the case conference minutes from part 1 of the meeting.

Adults at risk are entitled to a verbal or written summary from (part1) of the case conference, if requested by the Adults at risk, or as part of the communication strategy as agreed at the case
conference. The adult at risk's identified representative will be sent a copy of the summary with the consent of the adult at risk or if a best interest decision has been made under the Mental Capacity Act or as part of the communication strategy as agreed at the case conference.

Minutes from (part 2) of the case conference will be sent to the adult at risk and or representative automatically where they have attended. Where the adult at risk or representative have not been in attendance minutes will be sent with the consent of the adult at risk or if a best interest decision has been made under the Mental Capacity Act to share the minutes or as directed by the communication strategy as agreed at the case conference. Information provided needs to be in a format commensurate to the needs of the adult at risk.

Please note perpetrators of abuse whether they are an adult at risk/service user or an employee are covered by the Data Protection Act. Consequently the sharing of any identifiable information about them that may appear in the minutes must be appropriately redacted.

4.8.4 (i) Levels of Harm Investigatory and Panel Information.

Harm leaves panel investigatory report and feedback will not be shared outside of the panel attendees. Adults at risk and or their representative are entitled to a verbal or written summary if requested.

4.8.5 Sharing with The Care Quality Commission

As per the CQC Our Safeguarding Protocol - February 2013, the outcome of all safeguarding investigations including reports and action plans must be shared with CQC where it relates to a regulated service, whether or not CQC have been directly involved in the assessment or investigation process.

Therefore all adults protection meeting minutes relating to a regulated service will be shared with the CQC. The minutes must be encrypted and password protected before being sent to CQC central email address

For further details of the CQC protocol go to: http://www.cqc.org.uk/sites/default/files/media/documents/20130123_800693_v2_00_cqc_safeguarding_protocol.pdf

4.8.6 Sharing with the Disclosure and Barring Service

In most cases it will be the responsibility of the perpetrator’s employer to refer to the DBS for consideration for barring. It is appropriate to share minutes with the DBS as they will form part of the evidence for consideration in their decision whether to bar. However it is important to remember that the minutes remain the property of Stockport Council and should only be shared with the DBS in a redacted format and as agreed with Stockport Council. There is a legal responsibility under the Vulnerable Groups Act 2006 to share information with the barring authority. The responsible manager should ensure that employers of witnesses to adult abuse are made aware that Stockport Council cannot guarantee anonymity when sharing safeguarding information with the DBS. The DBS will share all safeguarding information including witness statements with the perpetrator to allow them an opportunity to present a defence before the DBS makes a final decision to place them on the barred list.
The principle is that we disclose fully but with the proviso that there may be a need (e.g. to protect an anonymous Alerter, prevent unnecessary disclosures of investigation processes), whereby there is some redaction required.

Some perpetrators will automatically be barred following a related criminal conviction. (Please go to: www.gov.uk/government/.../disclosure-and-barring-service for more information)

4.8.7 Sharing with the Coroner’s court

All coroner’s inquests are held in public in accordance with the principle of open justice. The record of the inquest including evidence provided to the inquest becomes a matter of public record. The coroner has the right to request information obtained during a safeguarding investigation and services have a duty to assist the coroner’s court with their inquiries.

Following discussion with the coroner for Stockport the following process has been agreed to deal with such information requests.

It is the role of the responsible manager in relation to an open safeguarding case where the alleged victim has died, immediately before, at the point of the referral or during the investigation process, to contact the Coroner’s Office via email to inform them that the deceased person is subject to the safeguarding policy and procedures. This will ensure a clear understanding of roles and responsibilities when an adult at risk has died.

Any request by the coroner’s officer for the release of safeguarding information will be made in writing via the Adult Social Care Contact Centre or Pennine Care Access and Crisis Team. They will direct the information request to the relevant responsible manager. The responsible manager will seek advice from legal services and/or the data protection coordinator and should consider where the disclosure of particular information has the potential to place an individual at risk of harm if heard in open court.

4.8.8 Sharing with the Police

Information relating to abuse of an Adult at Risk will be shared with the police where they have been invited, or in attendance at the associated meeting.

In incidences where the police request information relating to abuse of an Adult at Risk; Information can be shared under Section 29 Data Protection Act 1998 for the stated purposes of preventing crime or catching a suspect.

The police are also entitled to make requests for information under section 29 (Crime and Taxation) Data Protection Act 1998.

The existing exemptions do not cover the disclosure of all personal information, in all circumstances. It only allows the release of personal information for the stated purposes and only if not releasing it would be likely to prejudice any attempt by police to prevent crime or catch a suspect.

4.8.9 Sharing of information with Independent advocate

The adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. If the adult has substantial difficulty in being involved, and where there is no one appropriate to support them, then the local authority has a duty to arrange for an independent advocate to represent them for the purpose of facilitating their involvement.
To support the adult at risk understanding the safeguarding process and outcome the independent advocate will be privy to the relevant safeguarding information and associated the minutes from case conference part two.

4.9 Use of independent advocates, Interpreters, Signers and other Communication Specialists

4.9.1 Use of independent Advocates

Under the Care Act 2014 all Local authorities have a duty to involve people in decisions made about them and their care and support or where there is to be a safeguarding enquiry or Safeguarding Adult Reviews. Involvement requires the local authority helping the person at risk to understand how they can be involved, how they can contribute and take part and sometimes lead or direct the process.

People should be active partners in to any enquiries/investigations in relation to abuse or neglect. No matter how complex a person at risks needs are, the local authority is required to involve people, to help them express their wishes and feelings, to support them to weigh up options, and to make their own decisions.

The duty to involve the adult at risk applies in all settings, including for those people living in the community and in care homes.

Use of Advocacy - The local authority must form a judgment about whether a person at risk has substantial difficulty in being involved with these processes. If it is thought that they do, and that there is no appropriate individual to support and represent them for the purpose of facilitating their involvement, then the local authority must arrange for an independent advocate to support and represent the person.

Many of the people who qualify for advocacy under the Care Act 2014 will also qualify for advocacy under the Mental Capacity Act 2005. The same advocate can provide support as an advocate under the Care Act and under the Mental Capacity Act. This is to enable the person to receive seamless advocacy and not to have to repeat their story to different advocates. Under whichever legislation the advocate providing support is acting, they should meet the appropriate requirements for an advocate under that legislation.

Please note that if a safeguarding investigation needs to start urgently then it can begin before an advocate is appointed but one must be appointed as soon as possible.

For further information regarding the Independent advocate service for Stockport Safeguarding investigations please see the related documents section.

4.9.2 Use of Interpreters, Signers and other Communication Specialists

All agencies need to ensure they are able to communicate fully with an adult at risk and witnesses and ensure that family members and professionals fully understand the exchanges that take place. The use of interpreters, signers or others with special communication skills must be considered when undertaking inquiries involving one or more of the following:

- Alleged victim and/or family members for whom English is not the first language
• Those with a hearing difficulty
• Those with a visual impairment
• Those whose disability impairs speech
• Those with specific language or communication disorders
• Those with severe or emotional behaviour difficulties.

Family members should not be used as interpreters within the interviews, although they can be used to arrange appointments and to establish communication needs.

However formal or informal the interviewing arrangements are, it is important that the adult at risk believes that he/she has been heard and taken seriously. Every effort should be made to enable an adult at risk to tell his/her story directly to those undertaking inquiries.

The interpreters’ role in translating direct communications is not to act as representative to the victim/family. The interpreter must translate the words that are used by the adult at risk and the question put by the interviewer - especially critical for sexual abuse allegations.

It may be necessary to seek further advice from professionals who know the adult at risk well. Suitable professionals are likely to be drawn from the following groups:
• Speech and Language Therapists
• Professional translators (including people conversant with British Sign Language)
• Staff from the Community Mental Health Team (CMHT)
• Specific advocacy/voluntary groups
• Social Workers/Community Nurses specialising in working with adults at risk with disabilities.

4.10 The Service User as the perpetrator

Abuse between adults at risk is still abuse even if the perpetrator lacks the mental capacity to understand what it is they have done. This is because the recipient of the abuse will experience the abuse regardless of who the abuse is perpetrated by.

If the alleged abuser is a vulnerable adult then information about his or her involvement in an adult protection investigation, including the outcome of the investigation, should be included on his or her case records in line with service guidance and practice.

If it is assessed that the vulnerable adult continues to pose a threat to others, then this should be included in any information that is passed on to service providers.

4.11 Carer Stress

It is acknowledged that abuse may have occurred due to carer stress. Whilst the outcome for the adult at risk is the same, the meeting should consider how services could be commissioned to alleviate pressures etc. The Police must be involved if the abuse is potentially criminal and likely to continue regardless of service input. Sharing of information must take place within agreed protocol.

4.12 Roles and Responsibilities

4.12.1 Stockport Council Adult Contact Centre and Pennine Care NHS Foundation Trust Access Team
The majority of alerts for adults at risk with the exception of adults under 65yrs with an enduring mental health condition should be progressed via the Adult Contact Centre.

The majority of alerts for adults at risk under 65yrs with an enduring mental health condition should be progressed via the Access Team within the Pennine Care NHS Foundation Trust.

All adults at risk with early onset dementia should be progressed via the Adult Contact Centre.

The only exceptions to the above process will relate to alerts that are raised directly with any currently allocated worker.

To enable the responsible manager to respond appropriately the access point will establish with the alerter:

- That the alleged ‘victim’ meets the definition for an Adult at Risk.
- That the adult at risk has consented to the adult protection alert being made and any subsequent related investigations.
- With regard to the alleged victim establish where possible:
  - What their view of the situation is and what outcome they would like to see
  - Their personal details and social circumstances
  - Services they received and agencies in contact with them
  - Details of the alleged abuse
  - Other events giving rise to concern
  - The alerter’s view of immediate danger to the vulnerable person.
  - Check records for previous contacts and interventions
- With regard to the Alleged Abuser (s) establish where possible:
  - Relationship to the Adult at risk
  - Do they live with the Adult at risk
  - Disability and capacity of the alleged abuser
  - Likelihood of further contact with alleged victim or to other adults at risk
  - Risk to other people/children
  - Services received and agencies in contact
  - Alerter’s judgement of the situation.
- Establish where possible other Key Information:
  - Action already taken by alerter
  - Perceived risk to others
  - Other agencies already involved
  - Immediate action that the referrer thinks is necessary
  - Action taken by health services
  - Police involvement
  - Other agencies involved in the identification of
  - Establish is the alerter requires feedback regarding the alter
  - Clarify any details on the alert which may not be clear, to enable the responsible manager to progress alert to the referral stage
  - Offer support and information to alerters in cases that do not meet the criteria
  - Assign the alert to responsible team.

4.12.2 Host Authority Responsibilities
Stockport Adult Social Care or Pennine Care NHS Foundation Trust has the responsibility for the coordination of any adult protection investigation where the alleged abuse occurred within the Stockport boundaries. The placing authority details will need to be ascertained at the point of alert as the placing authority retains the overall responsibility for the care needs of the alleged victim and/or abuser.

For further information see the ADASS protocol:

http://adass.org.uk/images/stories/Policy%20Networks/Safeguarding_Adults/Key_Documents/ADASS_GuidanceInterAuthoritySafeguardingArrangementsDec12.pdf

4.12.3 Out of Hours/Emergency Duty Team

The Out of Hours Referral and Information Officer should upload the alert information onto Carefirst and bring to the attention of the Out Of Hours Social Workers. The seriousness or extent of the abuse should be assessed in relation to the immediate risk to the adult at risk and any other vulnerable adults and children at immediate risk.

Consider what cannot wait for the area teams to pick up?

- Is there a need for an immediate place of safety?
- Are the police required?
- Is action required to preserve any forensic evidence?

Out of Hours must record any decision or actions taken on the Carefirst computer system or relevant reporting systems for Pennine Care NHS Foundation Trust.

4.12.4 Community based and Hospital based Health Staff

To raise safeguarding adult alerts, attend safeguarding adult meetings, contribute to investigations and lead on safeguarding adult investigations where appropriate.

The Serious Incidents reporting system does not remove the need to make a Safeguarding Adults alert to the Local Authority. The two processes should, where required, run parallel to each other.

4.12.5 The Care Quality Commission

CQC’s function in response to safeguarding concerns is primarily, as a regulator, to ensure that commissioners and providers of care have adequate systems in place to ensure the safety of adults at risk and promote compliance with the essential standards of quality and safety.

The main areas of partnership working in which CQC may be involved in local Safeguarding Adult procedures:

- Information sharing.
- Safeguarding adult meetings.
- Local safeguarding boards.
- Serious case reviews.

CQC is the statutory regulator and should be informed of any concern about adult safeguarding/protection within a regulated service. All safeguarding minutes must be shared with relevant regulatory inspector.

4.12.6 The Disclosure and Barring Service (DBS)
The DBS do not investigate the cases referred to them under the Vulnerable Groups Act 2006. They make a decision to bar an individual from working with children or adults at risk based on the information sent to them. Therefore it is essential that any investigation is thorough and provides DBS with adequate information.

4.12.7 The Police

- Is to investigate crime. Under this policy any police investigation will take primacy. If the police are the lead investigating organisation, they will conduct interviews in a way to achieve best evidence under the provisions of the Youth Justice and Criminal Evidence Act 1999 (PACE)
- Is to ensure that the responsible manager of the safeguarding process is kept informed of the police investigation and outcome.
- Is to attend safeguarding adult meetings as appropriate and contribute to the outcome of any investigation

4.12.8 The Coroner’s court

A coroner’s inquiry considers violent or unnatural death, sudden death of unknown cause and deaths which have occurred in prison/custody.

The purpose of the coroner service when a death is reported is to:

- establish whether a coroner’s inquest is required
- establish the identity of the person, and how, when, and where they came by their death.
- assist in the prevention of future deaths; and
- provide public reassurance.

In specific cases where a death has been reported to the coroner and an inquest is to be held and an allegation of abuse has been alleged, the responsible manager should liaise directly with the coroner’s office before proceeding with a safeguarding investigation.

4.12.9 The Responsible Manager

A responsible manager under this policy and procedure is one of the following:

- Adult Safeguarding and Quality Team Manager
- Adult Social Care Team Manager/ Integrated Neighbourhood Lead
- Pennine Care Team Manager
- Integrated Neighbourhood Team Nurse (Band 6,7&8)
- Pennine Care Deputy Team Manager
- Adult Social Care Assistant Team Manager/Integrated Neighbourhood Team
- Adult Social Care Senior Practitioner
- Pennine Care Service Manager
- Adult social Care Service Manager
- Adult Safeguarding and Quality Service Manager

It shall be the decision of the responsible manager to assess and where appropriate progress the alert to a referral, or to close down. Following further consideration, the referral stage is the
acceptance by the responsible manager to either progress the referral under this policy and procedures to a strategy meeting/discussion or to close the referral down.

It is the responsibility of the responsible manager to ensure an Inquiry Officer is appointed as soon as possible.

It is the responsibility of the responsible manager to ensure that an independent advocate is appointed where the adult at risk has substantial difficulty in being involved in the safeguarding process and there is no one suitable to support the adult at risk.

When assessing the seriousness or extent of abuse the responsible manager will take into consideration:

- The **vulnerability** of the adult at risk
- The **extent** of the abuse
- The **length of time** it has been occurring
- The risk of **repeated or increasingly serious** acts involving this or other adult(s) at risk.

It is the role of the responsible managers to convene and chair all meetings held under this policy and procedures. It is the role of the responsible manager to ensure the investigation is completed within the timescales stated within this policy. If timescales are not met the reasons why should be recorded as part of the strategy and/or case conference minutes; for the purpose of audit by ASC and CQC.

### Time Scales

- **Immediate** action must be taken following an alert to safeguard anyone at immediate risk.
- A decision to progress an alert to a referral must be made within the **same working day**.
- Strategy meeting should be convened as soon as possible within **five days** of receipt of the alert.
- The investigation should be completed within **25 days of the alert**.
- A Case Conference meeting date must be set within **28 days** of the alert to address the outcome of the Investigation
- Review dates if required must be set at the Case Conference

It is the role of the responsible manager where the alleged victim has died immediately before, at the point of the referral or during the investigation process, to contact the Coroner’s Office via email to inform them that the deceased person is subject to the safeguarding policy and procedures. This will ensure a clear understanding of roles and responsibilities when an adult at risk has died.

### 4.12.10 The Inquiry Officer

An Inquiry Officer under this policy and procedure is one of the following:

- Social Worker (Adult Safeguarding and Quality Team)
- Social Worker (Adult Social Care Community Team/Integrated Neighbourhood Team )
- Nurse Integrated Neighbourhood Team
- Community Learning Disability Nurse
- Community Psychiatric Nurse (Pennine Care)
- Occupational Therapist (Pennine Care)

An Inquiry officer will have completed the appropriate Inquiry Officer training or be deemed by their manager to have the knowledge and skills to carry out an investigation with management support:
The inquiry officer where appropriate will conduct preliminary inquiries with the alleged victim to ascertain consent, capacity and clarification of the allegation.

The inquiry officer is responsible for planning, completing and coordinating the adult safeguarding/protection investigation. In most cases the Inquiry Officer will take the lead role in the investigation where the abuse has taken place in a family/wider community setting and there is no criminal investigation being undertaken by the police.

The inquiry officer maybe required to carry out a formal Mental Capacity assessment in line with the Mental Capacity Act 2005 if required.

The inquiry officer may be required to take on the role of Decision Maker as defined under the Mental Capacity Act. In doing so they will need to act in the adult at risks Best Interest and follow the guidelines as set out in the Mental Capacity Act code of practice.

For the full code of practice go to: http://webarchive.nationalarchives.gov.uk/+/http:/www.justice.gov.uk/docs/mca-cp.pdf

Where required the inquiry Officer will make the referral to Independent Mental Capacity Advocate Service. http://www.advocacyexperience.com/our-services

IMCA - Independent Mental Capacity Advocate.

There is a legal requirement under the Mental Capacity Act 2005 to consider the instruction of an IMCA for an adult at risk who is the focus of adult protection processes that includes protective measures and that person lacks capacity to make decisions about their own safety. The need to instruct a local IMCA should be considered at the strategy meeting stage and the outcome minuted. The power to appoint an IMCA for the purposes of adult protection is not dependant on the person being unbefriend.


Interviewing

It is the responsibility of the Inquiry officer to interview and consult with those persons identified at the strategy meeting.

It should not be assumed because the person lacks capacity to consent to the investigation they cannot be interviewed about what has happened to them. The decision regarding who and how to interview should be discussed and addressed at the strategy meeting.

It is the responsibility of the inquiry officer to interview and support through the interview process, both the adult at risk and the person allegedly causing harm where that person is an unpaid carer or another service user.

Where alleged abuse occurs in a service setting or where commissioned services are implicated in the abuse, a senior manager from that provider service will lead in interviewing staff members.

The inquiry officer will work alongside a Quality Assurance Officer from the Adult Safeguarding and quality service to offer guidance and support to the senior manager conducting the investigation. A thorough investigation process requires a commitment to joined up working to ensure a robust inquiry which is in keeping with the requirements of the Care Act 2014.

It is the responsibility of the inquiry officer to attend and contribute to all safeguarding meetings.
It is the responsibility of the inquiry officer to ensure appropriate recording whether electronically or paper based.

It is the reasonability of the inquiry officer to provide a written report of the investigation and its outcome for consideration at the case conference.

The inquiry officer should complete the first draft of the protection plan for consideration at case conference.

It is the responsibility of the inquiry officer to liaise with the alleged victim and/or their representative regarding:

- Attendance at case conference (part 2).
- Progression of the investigation as it occurs.
- Details of the investigation outcome.
- The opportunity for independent feedback on their experience of the Adult Protection process via the Service User Evaluation questionnaire.

4.12.11 The Adult Safeguarding and Quality Service – Quality Assurance Officers

To assist the process of investigation where there is a contracted provider service implicated.

To participate in the strategy discussion/case conference meeting as appropriate and contribute to the outcome of the safeguarding outcome.

To visit the service where required on an unannounced basis.

To provide a written report relevant to their findings.

Quality Assurance Officer will hold responsibility for the examination of:

- Service User care records
- Staff personnel files
- Staff rotas
- Staff Training records
- Environment (Residential Settings).

Quality Assurance Officers will work with provider on improvement plans devised as part of the safeguarding process to ensure quality care and contract compliance.

4.12.12 Adult Social Care/Pennine Care NHS FT Senior Managers

The responsibility for adult protection measures remains the responsibility of the relevant teams.

The role of senior management is to support the adult protection process and to ensure effective implementation of this policy and procedure.

Senior managers may be required to be the responsible manager in specific adult protection meetings, serious concerns about a service meeting.

4.12.13 Providers Managers
The general assumption is that registered and non-registered provider managers are judged to be fit and where they are not implicated in the alleged abuse, they will be pro-actively involved as partners in addressing the alleged abuse.

The manager of the service (where not implicated) will be expected to take the lead regarding any internal investigation process.

The manager/senior manager will be required to comment on the mental capacity of the alleged victim and/or perpetrators. It is the responsibility of the manager/senior manager to inform CQC, where appropriate and to report on any RIDDOR issues.

The manager/senior manager will need to provide any relevant additional information regarding the alleged victim and/or perpetrators. It is the responsibility of the manager/senior manager to take the lead in interviewing all staff who may be relevant to the investigation. This may include those implicated, witnesses or those with particular knowledge of the victim and/or perpetrator.

It is the responsibility of the manager/senior manager to provide a formal report for consideration at case conference.

4.13 Operational Procedures

The following paragraphs describe the key stages of the procedure. The precise actions necessary in any individual case will vary according to the circumstances and therefore the stages may overlap depending on how the investigation develops.

4.13.1 Actions prior to Strategy meeting

The safeguarding procedure should be person-centred and compliant with the principles of making safeguarding personal, therefore

- Is a risk assessment/action plan required before the strategy meeting to prevent any further abuse occurring,
- Establish with the adult at risk and or the representative what their desired outcomes and actions are in relation to the safeguarding issue presented.
- Consider if a crime has been committed

The Responsible Manager will appoint an Inquiry Officer.

The responsible manager will liaise with the Police and Coroner’s Office where required before any pre-strategy visit is undertaken if the allegation is a potential crime. The adult about whom there is a concern should be supported in a way which does not jeopardise any investigation or criminal prosecution.

Where appropriate the inquiry officer will conduct a first stage strategy visit to the adult at risk to ascertain capacity, consent and clarification of the allegation. The inquiry officer will ascertain if there is any specific communication requirement and need to appoint an independent advocate (see section 4.9) Inquiry officers should meet with interpreters first to explain the nature of the inquiry and clarify any issues.

It is essential that the inquiry officer is person-led and outcome focused, and holds effective discussions with the adult at risk or their representative to confirm the causes for concern and agree the outcomes wanted and desired action to be taken. Such practice by the inquiry officer engages the adult at risk in conversation about how best to respond to their safeguarding situation in a way
that enhances their involvement, choice and control as well as improving quality of life, well-being and safety.

The adults at risk and or their representative should be offered the opportunity to meet with the inquiry officer if they wish to do so, so that they can tell the relevant professionals first-hand what has happened and what outcomes and action they would like to see. It is essential that the inquiry officer has taken all reasonable steps to ascertain the views of the adult at risk and or their representative and to convey these at the strategy meeting.

4.13.2 Capacity of the Adult at Risk

The inquiry officer will always start from an assumption that the adult at risk has the capacity to make the decision to engage or decline involvement in the investigation. Where there is doubt regarding capacity to make the decision the two stage test must be used followed by the four stage assessment (understand the question, retain information, use or weigh information and communicate decision).

4.13.3 Consent to the Investigation

To give valid consent the adult at risk needs to understand what they are consenting to i.e. the investigation process. Consent must be given voluntarily and freely without pressure and undue influence being exerted on the adult at risk to either engage or decline involvement in the investigation.

Such pressures can come from partners, carers or family members, as well as health or social care professionals. Inquiry officers should be alert to this possibility and where appropriate arrange to see the adult at risk on their own to establish that the decision is truly that of the adult at risk.

4.13.4 Use of the Process Leaflet

The first stage strategy visit will also provide an opportunity for the adult at risk to give their perspective on the situation and inform the inquiry officer as to how they would like to be informed of the inquiry process and subsequent outcome. At this stage a copy of the Safeguarding Process leaflet should be given to the adult at risk.

A copy of the leaflet in standard or easy read version can be downloaded from:

http://www.stockport.gov.uk/services/socialcarehealth/adultsocialcare/safeguardingadults/safeguardingadultsprofinfo

4.13.5 Multiple Victim Investigations

Users of Carefirst can access the Unique Investigation Number (UIN) process for storing investigation information where there are multiple victims

See EDRMS UIN Guidance in ‘Related Documents’.
4.14 The Strategy Meeting

Please refer to The Responsible Manager and Administrative Support Service Guidance in related documents.

4.14.1 The Purpose

Whenever there is a reasonable cause to suspect an adult at risk is being abused or is at risk of abuse, a process needs to be undertaken that ensures all agencies work together to develop as full an understanding of the position as possible. The purpose of the strategy meeting is to:

- Collectively consider the adult at risk and or representative’s desired outcomes and actions in relation to the presenting safeguarding issues.
- Establish the adults at risks involvement in the adult protection process
- Ensure effective multi-agency working
- Facilitate the sharing of relevant information
- Establish a common understanding of the overall scope of the inquiry required
- Determine the urgency and type of intervention required to protect a vulnerable person from further harm
- Serve as a forum to co-ordinate the initial responses of the key agencies and individuals that have a role in responding to the abuse allegation
- Ensure that any interventions are compatible with the law specifically Human Rights Act 1998, Mental capacity 2005 and are justified, proportionate and least intrusive.

Adult protection investigations may involve more than one line of inquiry, which can run concurrently, for example, disciplinary processes, serious untoward incidents investigations or criminal investigation. However, all such processes need to be discussed, agreed and coordinated at the strategy meeting.

4.14.2 Format and Timescales

Best practice would indicate that a formal strategy meeting is convened as soon as possible, within 24hrs and no later than five working days of the initial alert and discussions with the adult at risk.

An informal strategy discussion can be carried out for expediency via the telephone, face to face discussion between duty officer and the responsible manager and / or password protected and encrypted e-mail between relevant parties. In such cases this may be sufficient to direct the investigation or close the adult protection referral down. Where it is not sufficient and further clarification/information is required a second strategy discussion via formal meeting may be required.

It is the responsibility of the responsible manager to ensure all informal strategy discussions are appropriately recorded.

4.14.3 Who should attend Strategy Meetings?

Attendance– This is NOT an open meeting, attendance/consultation should be limited to those key individuals representing agencies who may have a direct role/ responsibility to protect the individual or conduct the investigation.
Careful consideration should be given to attendees. Responsible managers need to be clear what role each attendee has in relation to the planning of the investigation or what responsibility they have for the safety of the adult at risk.

If it is not clear that the individual has a direct role in the investigation, the responsible manager is entitled to ask attendees to leave the meeting.

Any organisation requested to attend a strategy meeting should regard the request as a priority. The representative from that organisation should be sufficiently senior to take responsibility for any agreed actions.

If a crime is thought to have been committed the police must be one of the parties involved in the strategy discussions. If the alleged perpetrator is a member of staff in a regulated service, then the Care Quality Commission (CQC) must be involved, the relevant HR department also need to be informed.

People who may be required as a witness in the inquiry should not be involved in this process at this time.

The alleged perpetrator or the representative of an agency, who is implicated through an accusation, collusion or failure to respond to previous complaints, should not attend the strategy meeting.

4.14.4 Agenda Planning

Responsible Managers are advised to consult the safeguarding adults Strategy Meeting agenda pro-forma which is available electronically on EDRMS for Carefirst users and in hard copy format for non-Carefirst users.

4.14.5 Confidentiality agreement

The responsible manager needs to ensure that all attendees have read and understood the confidentiality policy. Information shared at the strategy stage is strictly confidential. The information should not be shared for any purpose other than the protection and care of adult(s) at risk of abuse and/or neglect.

4.14.6 Valid Consent of the Adult of Risk

The Responsible Manager will clarify if valid consent has been granted. For consent to be valid it must be given voluntarily by an appropriately informed person who has the capacity to consent to the investigation in question. If the person does not know what the investigation entails this does not constitute consent.

4.14.7 Mental Capacity of the Adult at Risk

The responsible manager will clarify the capacity of the alleged victim and ensure it is recorded within the minutes.

In the case of an incapacitated individual the responsible manager will ensure that any assessment undertaken in relation to capacity and the investigation are time and decision specific, and recorded appropriately.
4.14.8 Safety of the Adult at Risk and Others

Ensure the details of any immediate plan that has been put in place to protect the adult at risk from further harm are cascaded to the right people. Check that there is no unaddressed risk.

Identify whether there are children at risk (under 18 years), and where appropriate agree a referral to the children and family service and who will make the referral.

Be mindful that adults with capacity may choose to remain in situation of risk and decline offers of risk reduction interventions.

4.14.9 Clarifying what has Happened or been Alleged

- What is the concern/allegation
- What is known about the situation to date
- When did it happen
- Where did the alleged abuse take place
- Are there any witnesses
- Are there details of any witnesses?
- Who reported it
- When did they report it
- How was it reported
- What impact is this having on the adult at risk?
- What is the adult at risk is saying about the abuse?

4.14.10 Details of the Alleged Perpetrator

- Name
- Age
- Address
- Gender
- Relationship to alleged victim.
- Are they the adult at risk’s main carer?
- Are they living with the adult at risk?
- What is their role?
- Are they employed through a personal budget?
- Which organisation are they employed by?
- Are there other people at risk from the person causing the harm
- Are they a member of staff, paid carer or volunteer?
- Is the alleged perpetrator an Adult at Risk
- Has the alleged perpetrator been suspended if an employed worker

4.14.11 Establishing the Categories of Abuse for Investigation

It is essential that there is clarity for all present at the Strategy Meeting of the categories of abuse that are being investigated with the proviso that further categories e.g. institutional abuse may be identified during the investigation and will need to be considered at the Case Conference stage.

- Domestic Violence
• Sexual
• Psychological/emotional
• Financial or material
• Modern Slavery
• Discriminatory
• Organisational/Institutional
• Neglect and acts of omission
• Self-neglect


Agreement must be reached at the strategy meeting about the respective roles and responsibilities of the organisations involved in the investigation.

This could include:

• Agreement on who takes lead responsibility. The Care Act 2014 places a duty on the Local Authority to make enquires or cause others to do so, if it believes an adult is experiencing or is at risk of abuse or neglect. Thus depending on where the abuse took place and who the alleged abuser is, other organisation may be required to take the lead in the investigation process.
• Where the adult at risk is in a temporary setting e.g. hospital, the lead responsibility will be agreed in line with current service protocols
• Who will be responsible for carrying out what actions and when. This is particularly significant with regard to who and how they are interviewed.
• What are the tasks to be undertaken by the Inquiry Officer?
• What tasks will be undertaken by Quality Assurance Officer.
• What tasks will be undertaken by the employer.
• The best use of skills. Is there an expert witness e.g. Tissue Viability Nurse involved in the inquiry? If so what specifically can they contribute to the investigation?
• Communication strategy. What communication is required specific to the inquiry, who need to communicate what and to whom. E.g. Adult at risk, Adult at risk representative, Alert, Referrer.

4.14.13 Further Consultation with the Police

If information comes to light at the strategy meeting, that wasn’t previously available and it indicates a crime may have been committed. The police must be re-consulted to consider an appropriate response.

This may require a plan A and plan B response to prevent unnecessary delays without interfering with the police inquiry.

4.14.14 Closing the Adult Protection Process at the Strategy Meeting Stage

A consensus should to be reached with regard to the progression of the adult protection investigation or if it is appropriate to outcome at the strategy meeting. Decisions about no further action can be made at this stage, any decision and the reason(s) for it also need to be recorded.

The adult protection process can be completed at strategy stage.
The responsible manager and those in attendance at the strategy meeting will need to be satisfied that to outcome at this stage, nothing further is gained by continuing the investigation for example where:

- There is no case to answer.
- The abuse can be substantiated because the perpetrator is another adult at risk, the abuse was witnessed and the provider has carried out all the appropriate risk reduction actions required. A review may be required in such cases under care management.
- There are adult protection concerns, but the meeting agrees they are better dealt with under an alternative process e.g. an investigation by the Quality Assurance Team or continued input via Social Work Case Management/ Care Program Approach.
- There are adult protection concerns, but the adult at risk has mental capacity, is living at home and they are confident that they can protect themselves from further harm and they do not wish any action to be taken under the procedures. If undue influence or coercion is a factor in the abuse other social worker processes may be required such as referral to
  - The MARAC process
  - Stockport Without Abuse
  - The Department for Work and Pensions if the concern is about the misuse of appointeeship or fraud in relation to benefits.

4.14.15 Scheduling the Case Conference

Where a decision is made to proceed with investigation, the responsible manager must set a case conference meeting date to discuss the outcome of the inquiry within 28 days of receipt of the alert.

4.15 The Investigation

4.15.1 The Purpose

The purpose of the investigation is to establish the facts and contributing factors leading to the referral. Additionally there is a responsibility to identify and manage risk to ensure the safety of the individual and others.

It should seek to clarify the views of the adult at risk, enable a mental capacity assessment to be carried out if required and instruct an IMCA if that is indicated.

The adult protection investigation may well contribute to other lines of enquiry or assessment, such as:

- a police prosecution
- other court processes i.e. identifying powers to protect the adult at risk, for example, a restraining order.
- actions under civil law, for example, an injunction
- staff disciplinary proceedings
- A community care assessment or assessment under CPA
- A healthcare assessment.

Referrals to:
- The DBS
- The CQC in relation to a registered provider
• The commissioners of the service i.e. via the Quality team SMBC, NHS CHC in relation to breach of contracts.
• Referrals to other professional bodies e.g. NMC, HCPC, GMC
• A landlord in relation to a breach of the perpetrator's tenancy agreement.

4.15.2 Inquiry Officer Role within the Investigation Process

The main role of the inquiry officer is to interview and support the alleged victim throughout the adult protection process. The inquiry officer is responsible for planning, co-ordinating and managing the adult protection inquiry as determined by the Strategy Meeting. This does not necessarily mean that they will undertake all the tasks but they are responsible for ensuring that the investigation is carried through and that information is recorded on the case record.

At the beginning of an adult protection investigation the inquiry officer will:

Consider, in conjunction with the responsible manager, the outcome of the strategy meeting/discussion, and the need for:

- Risk assessment
- Protective measures and the IMCA Service
- Medical examination
- Consultation with carers/family
- Inquiry officer as decision maker.

4.15.3 Risk Assessment

Any response to an abuse allegation or concern will require an assessment of risk and plan to reduce risk to the lowest possible form.

An adult protection risk assessment will determine:

• what the actual risks are – the harm that has been or may be caused and the level of severity of that harm and the views and wishes of the adult at risk
• the person's ability to protect themselves
• who or what is causing the harm
• factors that contribute to the risk, for example, personal, environmental or relationships that result in increased or decreased risk
• the risk of future harm from the same source.

Any plan to manage the identified risk may require protective measures.

Specific risk assessment guidance and documentation is available electronically on EDRMS for Carefirst users and in hard copy format for non-Carefirst users

4.15.4 Protective Measures and the IMCA Service

Protective measures defined by the Mental Capacity Act include measures to minimise risk of abuse or neglect.

The regulations state that IMCAs may be instructed where local authorities or NHS bodies “propose to take or have taken protective measures in relation to an adult at risk that lacks capacity to agree
to one or more of the measures” and where adult protection proceedings have been instigated. People at risk may be supported by an IMCA regardless of any involvement of family or friends. See [http://www.scie.org.uk/publications/guides/guide32/files/guide32.pdf](http://www.scie.org.uk/publications/guides/guide32/files/guide32.pdf)

### 4.15.5 Medical Examination

Where medical attention has already been obtained, for example in a serious or life-threatening situation, a medical report should be requested.

In other situations, consideration should be given to the need for a medical examination. Consultation with the police may inform a decision regarding medical intervention and in particular, whether a police surgeon should be involved and any injuries photographed. Otherwise the person’s GP may be asked to undertake the examination.

In cases of alleged sexual abuse, decisions regarding medical examination must be taken in consultation with the police. It is likely that such a medical examination would be undertaken by a police surgeon at St. Mary’s Sexual Assault Centre rather than by the GP.

For further information go to: [http://www.stmaryscentre.org/](http://www.stmaryscentre.org/)

In some cases, a decision regarding medical examination may not be clear. The following factors should be considered:

- Length of time elapsed since an alleged assault
- Distress likely to be caused to the adult at risk by an examination
- Significance of information likely to be gained from an examination
- Whether the adult at risk has the capacity to give informed consent but is refusing examination. If it is decided not to seek a medical examination the reasons for this must be recorded.

The consent of the adult at risk to medical examination must be obtained and the doctor made aware of the reason for the request for examination and the possibility that a medical report may be required. If the adult at risk lacks the mental capacity to give informed consent for a medical examination at that time, a best interest decision will need to be made by the doctor.

When a medical examination is arranged, it should be conducted in a comfortable and non-threatening way. If possible the adult risk should be accompanied by someone who knows him / her well.

### 4.15.6 Consultation with Carers and Family.

Consent must be sought from the Adult at Risk before any information is shared. Where consent cannot be given a Best Interest decision has to be made prior to sharing information. Where there is a legal power held by a family member or carer e.g. LPA, Deputyship, due consideration must be given to their entitlement to receive information.

Family members and carers may need support in understanding and coming to terms with the abuse and information about the investigation and its possible outcomes. A clear communication strategy should be agreed at the Strategy Meeting stage. Parental or third party consent is not required for any medical examination of an adult. If the adult lacks the capacity to consent to a medical examination parents, family members or carers may be consulted with as part of the Best Interests process but the medical examiner will be the decision maker.
Sometimes it is an informal carer or family member who is suspected of abuse. In cases where police consultation has taken place, this should have addressed the issue of how the carer is to be approached. In other cases, with the consent of the adult at risk, the abuse concern should be discussed openly with the carer as part of the adult protection inquiry.

Please be aware that where a carer or family member is the alleged perpetrator this does not remove their right to be consulted with in any Best Interest process.

4.15.7 Decision Maker under the Mental Capacity Act 2005 in relation to sharing information

The Mental Capacity Act places a duty on the decision maker to consult with other people close to the person who lacks capacity. The decision maker has a duty to take into account such people’s views where it is practical and appropriate to do so in considering best interest decisions.

In cases where the adult at risk lacks capacity to consent to information being shared with family members in a safeguarding investigation, a best interest decision should be made. The inquiry officer will be the decision maker in such situations. Adherence to the Mental Capacity Act code of practice is required even if the family member is the alleged perpetrator.

This policy acknowledges the sensitive balancing act of protecting the adult at risk while adhering to the relevant statutes. The inquiry officer should seek clarification and guidance from the responsible manager where required.

4.15.8 Supporting the Adult at Risk through the Process

The Care Act 2014 requires professionals to work with adults to establish what being ‘safe’ means to them and how that can be best achieved. Professionals and other staff should not be advocating safety measures that do not take account of individual wellbeing as defined in section 1 of the Care Act.

Safeguarding is not a substitute for commissioners or providers negating their responsibility to provide safe and high quality care and support.

Regardless of whether the adult at risk has mental capacity their voice should be heard. They should be the first person to be interviewed to establish what has occurred and what they want to happen. They should be kept informed of the process as and when it occurs. Consideration should be given to individual communication needs.

The adult at risk should be prepared for interview by informing them of:
- The purpose of the interview
- How the information they provide may be used
- The boundaries of confidentiality and information sharing
- What will happen next. The inquiry office should go through and complete the Safeguarding Adults Process leaflet:
  - Standard version
    http://www.stockport.gov.uk/2013/2996/41143/safeguardingadultsprocessleaflet
  - Easy Read version
    http://www.stockport.gov.uk/2013/2996/41143/safeguardingadultsprocesseasyrea
- Their right to have someone present during the interview to support them.
4.15.9 Achieving Best Evidence

If there is a police investigation, where appropriate the police will ensure that interviews with the adult at risk, who is a vulnerable or intimidated victim or witness, are conducted in accordance with ‘Achieving Best Evidence in Criminal Proceedings’. Special measures are those specified in the Youth Justice and Criminal Evidence Act 1999 and will be used to assist eligible witnesses.

The measures can include the use of screens in court proceedings, the removal of wigs and gowns, the sharing of visually recorded evidence-in-chief, cross-examination and re-examination and the use of intermediaries and aids to communication.

If you are of the view the victim falls within the remit of the protocol you should discuss this with the police at the earliest opportunity.

4.15.10 Interviewing the Victim

Outside of a police led criminal investigation, the inquiry officer will interview the alleged victim in all cases irrespective of where the abuse took place or who the perpetrator is. This will be done following consultation and in partnership with the police and other relevant partner agencies.

Ideally two workers should undertake the interview so that the tasks of interviewing and recording can be shared and statements are witnessed.

The Inquiry officer and colleague should introduce themselves and clearly state who they are and where they are from.

It may be appropriate for the interview to be conducted jointly by professionals from different agencies.

In all cases, attention should be paid to the gender, ethnicity and culture of the adult at risk wherever possible.

4.15.11 Use of an Interpreter and Available Services

It may be necessary to involve an interpreter in order to enable effective communication during the interview. The interpreter may be required to explain any cultural issues relevant to the alleged victim that arise as part of the investigation. The interpreter’s availability will need to be considered when arranging the interviews.

The Police use Language Line which can be contacted on 0800 169 2879.
Web site www.languageline.co.uk
Stockport Council supports the use of the Ethnic Diversity Service. This is a team of trained interpreters, bilingual workers and teachers. They have capacity to interpret in over 35 languages. The service is free to all local authority employees with charging arrangements for others. Contact can be made on:
Phone - 0161 477 9000 Fax - 0161 480 1848 Email -eds.admin@stockport.gov.uk
Address: Ethnic Diversity Service, 3 Bann Street, Edgeley, Stockport SK3 0EX
4.15.12 Location of the Interview

The location for the interview must be comfortable and safe and where possible familiar to the adult at risk.

4.15.13 The purpose of the Interview

The purpose of the interview and the role of the interviewers should be clearly explained as far as possible at the beginning, dependent on the circumstances. The Inquiry Officer’s judgement supported by decisions and guidance from the Strategy Meeting which will inform what is said. There should be as much transparency of process as appropriate and the consent of the adult at risk obtained before the interview is recorded. Care must be taken throughout the interview to avoid asking leading questions. The interview should help to establish:

- The mental capacity of the alleged victim and or any other communication needs such as: Translation/interpretation/communication boards/a sign language interpreter/Makaton, use of speech and Language Therapist
- The nature and extent of the abuse: What, Where & When
- The circumstances and precipitating factors and any suspicious indicators. Is there any history or previous allegations?
- Specific details concerning the abuse and the alleged abuser. Ensure detailed information relating to times, dates and witnesses is captured.
- Any current visible evidence of abuse such as bruising which can be seen or shown to the inquiry officer.
- Whether the alleged victim understood they were being abused.
- Whether they were compliant with the abusive actions and if they were capable of giving consent.
- Whether any consent was given under duress or intimidation.
- The living situation of the alleged victim, including relationships and problem issues within the household, services received and agencies in contact.

4.15.14 Things to Consider

- Speak clearly and with empathy.
- Only use appropriate touch for communication purposes i.e. touching the hand of someone with dementia for reassurance.
- Be honest and clear but sensitive to the situation.
- Reassure the person that they have done nothing wrong.
- Explain the limitations of confidentiality.
• The issue of confidentiality should be revisited where required, as the person may disclose incidents of abuse other than those being investigated.

• It may be appropriate for the interview to be facilitated by someone who knows the person well or an advocate (as agreed at the strategy meeting). The inquiry Officer would need to be satisfied that the facilitator was not involved directly with the situation.

• It should not be assumed that a family member, carer would be the most appropriate person to facilitate the meeting. It may be distressing and embarrassing to discuss details of the abuse, which has occurred with family members and/or carers present.

4.15.15 Recording the Interview

The need to record the interview should be clearly explained to the adult at risk and their consent obtained. Where the adult at risk is not able to consent, a best interest decision should be made.

The interview will be recorded by means of written notes. It is necessary to have the questions that are asked clearly documented and the alleged victims responses recorded in their own words and as verbatim at possible. The information recorded will be an appendix to the Inquiry Officer Report.

Following legal advice the use of audiotape or videotape is not permitted by Inquiry Officer in adult protection interviews.

The inquiry officer will ensure the interview records are appropriately retained as part of the client record

4.15.16 The Inquiry Officer’s Report

The inquiry officer should complete a formal report for consideration at the case conference. The report will form the basis of the discussion at the case conference and the process of concluding the allegation of abuse.

When the alleged abuse has taken place in a service setting the inquiry officer report will detail the key findings from their own investigation/interviews and will include details of the internal investigators report.

The inquiry officer should send the report of the investigation to the responsible manager of the safeguarding case within 25 days of the alert being raised or as agreed at the strategy meeting.

See Inquiry Officer Checklist and Report on EDRMS or in ‘Related Documents’.

4.15.17 Interviewing when the alleged perpetrator is a family member/unpaid carer

The inquiry officer will interview the alleged perpetrator in cases where the alleged perpetrator is a family member or non-professional.

In cases where the alleged perpetrator or witness is a service user a decision will be made at strategy meeting who is best placed to carry out the interview.

Interviews with any perpetrators or witness will be done following consultation and in partnership with the police and other relevant partner agencies.
4.15.18 Internal Agency Investigation

A manager of the organisation where the alleged abuse took place will undertake the internal investigation as per Levels of Harm guidance levels 4 and 5. Please the Levels of Harm Guidance for further information.

This person will be known as the investigator as opposed to the inquiry officer. The investigator should be a suitably qualified and experienced member of staff working under the supervision of a manager. The investigator must not have direct line manager responsibilities for the person alleged to have caused harm.

They will be responsible for undertaking any interviews with staff who are witnesses and staff who are alleged perpetrators. Interviews shall take place within the disciplinary framework of the employing organisation. Any representatives or colleagues acting in the role of support to the alleged perpetrator must not be someone who may be called as a witness or be under suspicion of involvement or collusion in the alleged abuse. It is preferable for witnesses to be interviewed even when a statement has already been supplied.

If there is a criminal investigation, the police will be the lead organisation and any other internal investigations must be negotiated with them.

Issues the investigator may wish to consider:

- An analysis of the risks relating to the alleged victim and other vulnerable service users.
- Whether specific legal or human resources advice is required at this stage.
- Whether a temporary relocation or suspension of the worker is required and at what point they should be notified.

The investigator should complete a formal report for case conference including:
- A pen picture of the alleged victim
- Their capacity in relation to making decisions as to what action should be taken (if any)
- What is known about the alleged perpetrator
- The strength of the evidence currently available.

4.15.19 Internal Agency Investigation Report

The internal investigator should complete a formal report for consideration by the inquiry office pre case conference. The internal investigators report will be presented to the responsible manager by the inquiry officer.

The internal investigators report should demonstrate that they are satisfied they have fully investigated the alleged abuse within their service setting. The report should demonstrate what actions have been taken to address the presenting issue and associated risk, ensuring that all adults in their care are safeguarded.

The internal investigator should send the report of their investigation to the inquiry officer within 20 days of the alert being raised or as agreed at the strategy meeting.
Along with the inquiry officers report the internal investigator report will form the basis of the discussion at the case conference and aid the process of concluding the allegation of abuse.

To prevent confusion the internal investigators report should be clearly written and refer to people by their full name rather than use initials.

### 4.16 The Case Conference and Protection Plan

Please refer to The Responsible Manager and Administrative Support Service Guidance in related documents

An adult protection Case Conference may be called at any time during an adult protection inquiry. Best practice requires this to take place within **28 days of receipt of the alert.**

Some external investigations or processes may not be completed within this time frame, for example, a criminal prosecution or cases open to the Coroner.

To ensure the inquiry is kept to task and that a protection plan is put in place or reviewed as appropriate. The case conference should not be delayed in such instances.

In cases that involve criminal/coronial investigations that have not yet been to court the Responsible Manager will liaise with the police/coroner’s office on a case by case basis before making a decision as to whether or not the case can be outcomed at the case conference based on the evidence available, without waiting for the court outcome.

#### 4.16.1 The Purpose

The main purpose of the case conference is to evaluate the evidence and decide based on the balance of probability whether the abuse allegation meets one of the nationally agreed outcomes.

**A Case Conference will:**

- Consider the information contained in the inquiry officer’s report(s) and decide what further action is/may be needed.

- Consider the information contained in the organisation’s investigator’s report(s) and decide what further action is/may be needed.

- Consider any other relevant information.

- Make a decision about the levels of current risks and a judgement about any future risks.

- Agree a protection plan.

- Agree how the protection plan will be reviewed and monitored.

- Consider if legal or statutory action or redress is required. E.g. DBS, DOLS, Complaints, Serious Case Review.

- Decide what action is appropriate when the allegation has not been substantiated but concerns remain about standards of care.
• For non-Carefirst users a Safeguarding Adults Inquiry Outcome Form number AC O076 should be completed by the Inquiry Officer and sent to samcas@stockport.gov.uk

4.16.2 The Case Conclusion

The case conclusion for each allegation is selected from nationally agreed options as determined by the NHS Information Centre for Health and Social Care. These are as follows:

- Substantiated - fully
- Substantiated - partially
- Not substantiated
- Inconclusive

4.16.3 Further Case Conference

If the Responsible Manager/meeting attendees are not satisfied they are in position to outcome the investigation, further inquiries or gathering of evidence can be undertaken and an additional case conference called.

4.16.4 Planning the Conference

The responsible manager will ensure that a case conference is convened within the timescales. They will facilitate the case conference and ensure the minutes are taken in accordance with the responsible manager and minute takers guidance.

In arranging an adult protection case conference consideration must be given to the following:

**Responsible Manager** - Usually the line manager of the inquiry officer will be the responsible manager of the case conference. If the case is complex or contentious it may be appropriate for a Service Manager to chair/act as the Responsible Manager. A member of the Safeguarding Adults Mental Capacity Act Service (SAMCAS) may also take on the responsibility of the Responsible Manager.

**Venue** - Consideration must be given to the requirements of people who have disabilities or sensory impairments. In addition the responsible manager will ensure a table is available for the minute taker.

**Attendance** - The inquiry officer in conjunction with the responsible manager should identify the people to be invited to the conference, agreeing this wherever possible with the adult at risk. This should include those individuals coroner who can contribute to the protection plan and/or have relevant information to contribute. The Responsible manager or the adult at risk has the right to exclude the attendance of anyone whose presence is liable not to be in the best interest of the adult at risk and the reason why such a decision has been made should be recorded.

4.16.5 Format of the Case Conference

To help support the attendance and effective participation of the adult at risk, it is recommended that the case conference format and purpose is made clear.

The adults at risk and/or representative will be invited to attend the case conference.
In most cases the adult at risk and/or their representative will not be present for the whole of the case conference. Their exclusion from part of the meeting should be explicitly explained to the adult at risk and/or their representative, based on the need for confidentiality and the limits of information sharing. e.g. overlap with disciplinary procedures, need to discuss other individuals etc.

The professionals present may need to discuss other adults at risk by name and their alleged abuse or previous allegations relating to a commissioned service or confidential disciplinary or pending criminal proceedings.

4.16.6 Victim/Representative Attendance at the Conference

Responsible managers may decide to split the meeting into two parts:

**Part 1** - for professionals to receive the inquiry officer’s report and if appropriate the organisation’s investigating officer’s report and to make decisions on the findings. The attendees at this meeting will usually be the same as those of the Strategy Meeting unless otherwise agreed

**Part 2** - will involve agreeing the protection plan. The Adult at risk and/or their representative is entitled to attend this part of the meeting. However some adults do not participate well in larger formal meetings and this experience may be excluding and/or anxiety provoking. The inquiry officer in conjunction with the responsible manager should consider the best means to make a meeting accessible and inclusive for the adult at risk.

Whether the case conference is attended by the adult at risk and/or their representative or not, the Responsible Manager must give a clear indication at what point the business of Part 1 of the meeting has been concluded and the meeting is now moving to Part 2. This will enable all attendees to be clear that the minutes of the remainder of the meeting will be shared with the adult at risk and/or their representative.

If it is necessary in order to meet the adult at risk’s mobility and communication needs (if specialist facilities are required), a separate protection planning meeting should be held in a different venue. If this proves to be necessary, such a meeting should be held as close in time to the first part of the case conference meeting as possible.

4.16.7 Who Should Attend

- The Adult at Risk and/or their representative.
- Inquiry Officer.
- Responsible Manager.
- Organisations Investigating Officer.
- Any other key individuals as identified at strategy meeting.
- Legal Representation - if the adult at risk or their representative plans to bring their own legal representative, then Pennine Care or Stockport Legal Services should be invited to attend.

4.16.8 Deciding the Outcome

The responsible manager will summarise the key points of the investigation and the case conference discussions. This will assist the attendees to reach an outcome. The responsible manager will reiterate the standard of proof required to decide the outcome of the abuse allegation.
4.16.9 The Standard of Proof

The fact that there is insufficient evidence for a criminal prosecution does not mean that action cannot be taken under civil or disciplinary proceedings. The standard of proof for a criminal prosecution is higher, as the case has to be proved ‘Beyond Reasonable Doubt’. For civil, disciplinary or regulatory investigations such as an Adult Protection investigation the standard of proof is based on the ‘Balance of Probability’.

4.16.10 Reaching a Consensus

The responsible manager will ask each attendee starting with the inquiry officer to provide an outcome in line with the NHS Information Centre options (see 4.16.2 above).

Where a provider service representative has brought support staff e.g. HR advisor or regional manager to the case conference, such personnel will not be invited to provide an outcome. Adults at risk and or their reps will not be invited to outcome the abuse investigation. Their views will have been clearly communicated to the attendees via the inquiry officer’s report. The minute taker will record each individual’s outcome decision and the overall outcome for the case.

Where there is a lack of consensus regarding the outcome of the inquiry the responsible manager will endeavour to clarify the significant points of the case and encourage further discussion to enable consensus. If a consensus still cannot be reached the responsible manager will accept the majority decision. In the unusual case of a split 50/50 decision the responsible manager will make the final decision.

4.16.11 Consideration of Legal or Statutory Action

Employers, Adult Social Care and regulatory bodies such as the CQC and the NMC are under a legal duty to notify the Disclosure and Barring Service (DBS) of relevant information, so that individuals who pose a threat to vulnerable people can be identified and barred from working with such vulnerable people.

If an employee is dismissed or removed from working with vulnerable people (in what is legally defined as regulated activity) because they have engaged in ‘Relevant Conduct’ or satisfied the ‘Harm Test’, there is a legal duty to refer to the DBS. The same duty applies where the employee has terminated their own employment before any disciplinary proceedings could be convened or completed.

The responsible manager will clarify who will make the referral to DBS. In most cases this will be the employer. In cases involving direct payments or individual budgets the Local Authority will be required to make the referral to ISA.

4.16.12 Communication Strategy

The responsible manager will clarify who communicates what and to whom following the adult protection investigation.

In cases where the adult at risk and/or their representative has not been in attendance at the case conference the responsible manager must ensure that a clear communication strategy with the adult at risk and/or their representative is identified. This task will usually be undertaken by the Inquiry officer who will explain the outcome decision and detail any protective measures that directly affect the adult at risk.
Communication with the alleged perpetrator should be agreed at the case conference. In cases where the perpetrator is an employee the employer must feedback the outcome decision.

In cases where the alleged perpetrator is a service user in a service setting a decision will be made on a case by case basis what information needs to be communicated with that service user.

In cases where the alleged perpetrator is not an employee or service user a decision will be made on a case by case basis how to feedback relevant information such as case closure.

The responsible manager will ensure relevant feedback is provided to the Referrer where they have requested feedback or where the responsible manager thinks it is appropriate.

All feedback regarding the inquiry must be compliant with the principle of proportionality and be consistent with the Data Protection Act 1998, the Human Rights Act 1998 and the common law of confidentiality.

4.16.13 Service User Experience Survey

The responsible manager should highlight the opportunity for the adult at risk and/or their representative to give feedback on their experience of the adult protection process. If the decision is for the survey to be initiated the Inquiry officer should contact the Performance Information officer on 474 4613 who will make arrangements to send this out anonymously. The service user evaluation questionnaire will be sent out following the outcome of the abuse investigation.

For Carefirst users the guidance can be found on EDRMS. For non-Carefirst users please see related documents.

Where it is not appropriate to send the questionnaire or undertake face to face interviews the reasons must be clearly recorded in the minutes of the case conference.

4.16.14 Adult Protection Plan

The meeting will:

- Agree a protection plan with the adult at risk (or the person representing them) and decide which organisation will monitor and coordinate the plan.
- Agree contingency actions if the protection plan does not work.
- Agree how the protection plan will be shared with partners, taking into account information-sharing considerations.
- Provide support and services to meet the needs of the adult at risk and of a carer if that is indicated.
- Determine what additional information needs to be shared and with whom.
- Set a date for a review unless all organisations agree that a review can take place as part of the care management/CPA or health and social care process. If this is the decision reached, the reporting mechanism for the outcome of the review needs to be established and agreed (for example, information sent to the responsible Manager following the review).
- Where residual risk and concerns remain that do not come under the adult protection procedures a review date will be set and monitoring will be undertaken by the appropriate social work team.
- The protection plan will not include actions taken against the person causing harm.

(For Carefirst users a protection plan proforma is available on EDRMS and as a hard copy for non-Carefirst users)
4.17 Adult Protection Review Meeting, Monitoring & Care Act
Safeguarding Adult review (SAR)

The purpose of the review is to ensure that the actions agreed in the protection plan have been implemented and to decide whether further action is needed, including any service improvements. If a decision is taken at the case conference that a review is not thought to be necessary, the adult protection process will be closed. In this case a decision can be taken that the protection plan should be reviewed as part of the on-going care management or CPA processes.

Additionally a review meeting can be convened if:

- the adult at risk has capacity to understand the nature of a review and requests a review
- the person representing the best interests of the adult at risk requests a review
- the situation is assessed as high risk
- a review is requested by any organisation involved in the delivery of the protection plan
- the person coordinating the protection plan requests a review.

N.B. A new concern of abuse or neglect would be considered as a new alert/referral.

4.17.1 Who should attend the Review?

The review should be attended by all those who are involved in the protection plan and any services that may be able to provide support or may need to be involved in the future.

The adult at risk should be enabled to participate in the review on the same basis as for the case conference.

The attendance at the review of a carer or a personal representative would be on the same basis as their attendance at the case conference.

4.17.2 Purpose of the adult protection review

The review should:

-Review the risk assessment and protection plan.
- Decide about on-going responsibility for the protection plan.
- Decide in consultation with the adult at risk or their personal representative what changes, if any, need to be made to the protection plan to decrease the risk or to make the plan fit more closely with their needs.
- Record the feedback of the adult at risk or their personal representative about the protection plan and/or other matters of importance to them.
- Decide whether there is need for a further review and, if so, set a date.
- Decide whether to close the adult protection processes.

4.17.3 Closing the Adult Protection Process

The adult protection process may be closed at any stage if it is agreed that an on-going investigation is not needed or if the investigation has been completed and/or a protection plan is agreed and put in place.

In most cases a decision to close the adult protection process is taken at the case conference or review.
4.17.4 Actions on Completion

The responsible manager should ensure that, on conclusion of the process:

- All actions are completed or are in progress.
- All records are completed including Carefirst or equivalent.
- All evidence and decisions are adequately recorded and case records saved to EDRMS or equivalent and have had passwords removed.
- The person at risk knows that the process is concluded and where/who to contact if they have any future concerns about abuse.
- All those involved with the person know how to re-refer if there are renewed or additional concerns to enable referral to the appropriate professional bodies where necessary.
- The referrer is notified of completion within the limits of confidentiality.
- Feedback is sought from the adult at risk about their experience of the process and whether they are satisfied with the measures that have been put in place and if they feel safer via service user evaluation questionnaire.
- Is a referral to Stockport Council’s Safeguarding Adults Board required to consider if a Safeguarding Adults review (SAR) is required. SAR is required when:
  - An adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
  - SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.
  - There has been a near-miss or a fatality, and procedures do not appear to have been followed or agencies did not work together effectively.
  - A serious case review or independent management review could also be indicated where the adult at risk disagreed strongly with the outcome of the investigation and provisions of the protection plan.

Please see associated SAR guidance for further information [here](http://www.stockport.gov.uk/services/socialcarehealth/adultsocialcare/safeguardingadults/safeguardingadultsreviews/)

4.17.5 Incomplete Parallel Processes

The adult protection process may be closed but other processes may continue, for example, a disciplinary, professional body investigation, criminal investigation, coroner’s inquest etc.. These processes may take some time. Consideration may need to be given to the impact of these on the person at risk.

4.17.6 Evaluation and learning

All those involved in the adult protection process should reflect on the lessons learnt from individual cases and actively seek to improve practice and demonstrate how learning from such cases has improved services for adults at risk.