WELCOME

This resource is designed to help you access the information you need as easily as possible.

We welcome your feedback. If you have comments or suggestions to help us improve this resource please get in touch via email:

E: bsab@buckscc.gov.uk

In order to assist you the following icons have been used to link you to additional information.

- **Report**
  Live link to ‘Raising a concern’ form

- **Forms**
  Live link to the relevant form on various related sites

- **Links**
  Live link to external site / information source

- **Case studies**
  Link to relevant case study
As well as this full web based Multi-Agency Policy and Procedures, this document is also available in:

- **The web based version** (the version you are looking at)
  is easier to navigate as it is designed to help you go quickly to the relevant section.

- **Easy-read version**
  This is designed for people who may have difficulty in reading the full version.

- **Printable version of main document**

  **Think before you print!**
  This document has been made available in a printable version when it is not possible to access the complete web based version.

  **Please note:** The links in this printable version are not included as web addresses.
  The links are only available in the interactive web based version.

  **WARNING:** A printed copy can become out of date quickly as the web based version is updated regularly. Make sure you are using the correct version by checking the version number on the main document on the website.
INTRODUCTION

THE ABUSE OF ADULTS IN NEED OF CARE AND SUPPORT IS AN ISSUE OF GREAT NATIONAL CONCERN. AS A SOCIETY WE NEED TO COMMIT TO CHALLENGING ANY ACCEPTANCE THAT BEING ABUSED IS PART OF THE EXPERIENCE OF BEING AN ADULT IN NEED OF CARE AND SUPPORT.

To achieve this the Care Act 2014, and the statutory guidance that goes with it, has given a clear national framework for adult safeguarding new legal duties, to ensure we all have the tools and the authority to make reducing adult abuse a reality.

Developing a multi-agency policy and procedure to safeguard adults is a requirement of all Safeguarding Adults Boards who have the strategic responsibility to ensure that a robust, proportionate, timely and professional approach is taken when adults are at risk or experiencing abuse.

National and local experience of professionals and individuals who use services tells us that both increased awareness of adult abuse and improved collaboration between agencies are essential to improving the prevention and response to abuse and neglect. All organisations working with adults in Buckinghamshire have a responsibility to:

- Ensure they are aware of safeguarding adults issues.
- Ensure they are familiar with this policy and accompanying procedures.
- Ensure they are equipped to act in accordance with their responsibilities as outlined in this policy and procedures document.

This supports the Board’s statement that:

SAFEGUARDING IS EVERYBODY’S BUSINESS!

This Policy and Procedures document replaces the 2013 ‘Multi-Agency Policy & Procedures for Safeguarding Vulnerable Adults’.

It is best used in this online interactive format, however other versions are available:

- Print version
- Easy read

The case studies used in this policy are examples from the Care and Support Statutory Guidance 2016 and are all for indicative purposes only.
SAFEGUARDING PRINCIPLES

SIX KEY PRINCIPLES WHICH ARE ENSHRINED IN THE CARE ACT AND UNDERPIN EVERY ASPECT OF ADULT SAFEGUARDING

- **Empowerment**: People being supported and encouraged to make their own decisions and informed consent.
- **Prevention**: It is better to take action before harm occurs.
- **Proportionality**: The 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**: Transparency and integrity in delivering safeguarding.
KEY PRINCIPLES INFORMING THIS POLICY

BSAB consider that adult safeguarding work should be based on the following:

• No abuse is acceptable.
• Every person has a right to live a life free from abuse, neglect and fear.
• Safeguarding adults is everyone’s business and responsibility.
• Support is in place for adults to prevent abuse from occurring and following incidents of abuse.
• To empower adults.
• To support choice and attempt to meet the desired outcomes of the person.
• All reports of abuse will be treated seriously.

• Every person should be able, where possible, to access information about how to protect themselves from abuse and neglect.
• Adult safeguarding work is aimed at the prevention and / or the swift and proportionate response to abuse and neglect.
• All partner agencies and organisations across Buckinghamshire should work collaboratively to ensure accountability, transparency and appropriate professional challenge.

People working or involved with supporting adults have the appropriate knowledge, skills and training to effectively safeguard adults.

The Care Act and the Care Act guidance sets out the statutory requirement for local authority social services, health, police and other agencies to both develop and assess the effectiveness of their local safeguarding arrangements. This is founded on the six key principles below.
KEY PRINCIPLES INFORMING THIS POLICY

SAFEGUARDING PRINCIPLES

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

**SAFEGUARDING PRINCIPLES**

- Personalisation and presumption of person-led decisions. Informed
- It is always preferable to take action before harm occurs.
- Proportionate and least intrusive response appropriate to the risk
- Support and representation for those in greatest need
- Solutions through services working with communities who can detect, prevent and report abuse and neglect
- Accountability and transparency in delivering safeguarding
KEY PRINCIPLES INFORMING THIS POLICY

SAFEGUARDING PRINCIPLES

Six key principles underpin all adult safeguarding work:

**Empowerment**
People being supported and encouraged to make their own decisions and informed consent. “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”

**Prevention**
It is better to take action before harm occurs. “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”

**Proportionality**
The least intrusive response appropriate to the risk presented. “I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.”

**Protection**
Support and representation for those in greatest need. “I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.”

**Partnership**
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.”

**Accountability**
Accountability and transparency in delivering safeguarding. “I understand the role of everyone involved in my life and so do they.”
KEY PRINCIPLES INFORMING THIS POLICY

DIGNITY, CHOICE, EQUALITY AND DIVERSITY

The Buckinghamshire Safeguarding Adults Board is committed to ensuring that the adult, their families and carers are at the centre of the safeguarding process. We will ensure that people are listened to; have their views taken into account; are treated with respect and have their dignity maintained at all times.

Dignity in care is integral to all aspects of preventing and responding to abuse.

The Board recognises that society is made up of adults with diverse and unique identities. This is reflected in the Multi-agency Safeguarding Procedures.

Every intervention made by partner agencies will aim to take into account each person’s individuality to avoid discrimination on grounds of race, religion, ethnicity, age, gender, sexual orientation, disability, and language or lifestyle choice.
BSAB VISION

The purpose of our Board is to safeguard adults by;
✓ providing oversight, leadership, challenge and guidance
✓ holding partners to account to ensure that there are effective arrangements in place to prevent and respond to abuse and neglect

The partners to the BSAB are:
- Buckinghamshire County Council
- Buckinghamshire Healthcare NHS Trust
- Community Rehabilitation Company (CRC)
- Buckinghamshire District Councils
  - Aylesbury Vale
  - Chiltern and South Bucks
  - Wycombe
- Buckinghamshire Fire & Rescue Service
- Buckinghamshire’s Race Equality Council and Multicultural Centre
- Carers Partnership Board
- Care Quality Commission (CQC) Healthwatch Bucks
- HM Prison Service
- Milton Keynes and Buckinghamshire Care Association (MKB Care)
- NHS Aylesbury Vale Clinical Commissioning Group (CCG)
- NHS Chiltern Clinical Commissioning Group (CCG)
- Oxford Health NHS Foundation Trust
- SAFE (Safeguarding Adults for Everyone)
- Service Users & Carers
- South Central Ambulance Service
- Southern Health NHS Foundation Trust
- Thames Valley Police
- Thames Valley Probation
AIMS OF THIS POLICY

The aims of the BSAB Multi-agency policy and procedures are to:

- Promote an understanding and application in practice of the safeguarding principles and Making Safeguarding Personal (MSP)
- Inform and support anyone involved with or interested in, the safety and well-being of adults at risk.
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- Safeguard adults in a way that supports them in making choices and having control about how they want to live.
- Promote an approach that concentrates on improving outcomes for the adults concerned.
- Ensure the approach promotes the wellbeing of the adult, and is not just driven by the process.
- Promote public awareness of safeguarding to prevent or report abuse and neglect.
- Provide information and support in accessible ways to facilitate learning about the different types of abuse, how to stay safe and how to raise a concern about the safety or well-being of an adult.
- Reflect learning from incidents of abuse and neglect to improve prevention and response going forward.
SAFEGUARDING UNDER THE CARE ACT (2014)

THE STATUTORY FRAMEWORK FOR WORKING WITH ADULT SAFEGUARDING

SECTIONS 42-47 OF THE CARE ACT 2014

» SAFEGUARDING UNDER THE CARE ACT (2014)
» SECTION 42 ENQUIRY
» SECTION 43 – SAFEGUARDING ADULTS BOARDS
» SECTION 44 – SAFEGUARDING ADULTS REVIEWS (SAR)
» SECTION 45 – SUPPLY OF INFORMATION
» SECTION 47 – PROTECTING PROPERTY OF ADULTS BEING CARED FOR AWAY FROM HOME
» ADVOCACY
Sections 42-46 of the Care Act 2014 set out the statutory framework for working with adult safeguarding. This replaces ‘No secrets’ guidance, which was the previous point of reference for this area of practice.

- Section 42 – enquiry
- Section 43 – Safeguarding Adults Boards
- Section 44 – Safeguarding Adults Reviews
- Section 45 – supplying information
- Section 46 – abolition of Local Authority Power to remove persons in need of care
- Section 47 – protecting property of adults being cared for away from home

The Safeguarding Adults Board (SAB) has the statutory responsibility to ensure a robust, proportionate, timely and professional approach is taken when adults with care or support needs are at risk of, or experiencing abuse or neglect. As such, developing a multi-agency policy and procedure to safeguard adults with care and support needs is a requirement of all Safeguarding Adults Boards.

Both increased awareness and improved collaboration between agencies are essential to improving both prevention and responsiveness to abuse and neglect. All organisations working with adults in Buckinghamshire must ensure they are:

- aware of safeguarding issues
- familiar with these policies and procedures
- equipped to act in accordance with their responsibilities under this framework

This multi-agency policy and procedure support the SAB statement that:

**SAFEGUARDING IS EVERYBODY’S BUSINESS!**

Roles and responsibilities are described [here](#).
SECTION 42 ENQUIRY

Section 42 of the Care Act 2014 requires that each Local Authority must:

- Make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

- Where Mental Capacity is an issue or the adult concerned has 'substantial difficulty' in being involved in the process of a safeguarding enquiry, the Local Authority must arrange for them to be supported by an advocate. Where there is no other suitable person to represent them, an independent advocate must be provided.

- Co-operate with each of its relevant partners in order to appropriately protect the adult. In turn, partners must cooperate with the Local Authority.

The combined effect of section 42 and 79 of the Care Act is that the Local Authorities safeguarding responsibility cannot be delegated. The Duty on the Local Authority under s.42 is to "make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken…". The statutory service does not have to undertake the actual enquiry itself; it has to coordinate and quality assure the response, including the quality and outcomes of any delegated enquiry. There are three stages to the process of an enquiry:

(a) Commissioning the enquiry
(b) Undertaking the enquiry
(c) Deciding what action to take in light of the enquiry

Only the undertaking of an enquiry can be delegated by the Local Authority, (e.g. to Health, a Provider organisation etc.). Stages (a) and (c) must be undertaken by the Local Authority itself.
SECTION 43 – SAFEGUARDING ADULTS BOARDS

Every Local Authority must establish a Safeguarding Adults Board (SAB). This Board oversees and leads adult safeguarding across the locality and is responsible to help and protect adults in its area in accordance with s.42.

The SAB does this by coordinating and ensuring effectiveness of what each member organisation does (quality assurance and holding to account). The Act states “the SAB may do anything which appears to it to be necessary or desirable to achieve its objective”.

The SAB has three core duties:

1. To publish a strategic plan annually
2. To publish an annual report detailing what it has done
3. To conduct any Safeguarding Adults Review in accordance with s.44 of the Act.

Safeguarding Adults requires collaborative working. Each SAB should identify roles and responsibilities, establish ways of interrogating data, establish how it will hold partners to account, determine arrangements of peer review and self-audit, establish mechanisms for developing policies and strategies, deal with complaints, grievances and professional administrative malpractice in relation to safeguarding and challenge and hold agencies to account.
SECTION 44 – SAFEGUARDING ADULTS REVIEWS (SAR)

The SAB must arrange for a review of a case involving an adult in its area with needs for care and support if:

- There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult and
- The adult has died and the SAB knows or suspects that the death resulted from abuse or neglect (physically or psychologically).
- The adult is still alive and the SAB knows or suspects they have experienced serious abuse or neglect.

The SAB may arrange for a review of any other case.

Each member of the SAB must cooperate with a view to identifying lessons to be learnt and applying those lessons to future cases.

Considerations for ‘serious abuse’ where the adult is still alive, include; those where it is likely they would have died but for an intervention, suffered permanent harm, or have a reduced capacity or quality of life as a result of the abuse or neglect (physically or psychologically).

The SAB has to weigh up which type of review process is likely to promote effective learning and is proportionate and also mindful of any living individuals’ best interests.

The individual or their family should be invited to contribute to the review; they should be supported sensitively and their expectations managed. The SAR should reflect the six principles of safeguarding. The SAB should agree terms of reference, which are published and transparent. They should promote a culture of continuous learning and improvement and be proportionate according to the scale and level of issues. The SAR should be led by an individual independent of the case and the organisation whose actions are being reviewed. They should fully involve professionals without fear of blame for actions taken in good faith.

The aim of the SAR is to determine what could have been done differently that could have prevented harm or death. This so that lessons can be learned and applied in future. If lessons are to be learned, reviews have to be trusted and safe experiences that encourage honesty and transparency.
SECTION 45 – SUPPLY OF INFORMATION

The SAB may request information be supplied either to the Board, or to another person. The recipient of the request must provide the information if:

- The request is made in order to enable or assist the SAB to do its job
- The request is made of a person who is likely to have relevant information

Good record keeping is a vital component of safeguarding. Staff in all agencies should be given clear direction as to what information should be recorded and in what format. Records should be kept in such a way that the information can easily be collated for local use and national data returns. Information will be shared on a ‘need to know’ basis, when it is in the interests of the adult concerned. Confidentiality must not be confused with secrecy. Informed consent should be obtained, but if this is not possible and it is in the public interest or there is transferable risk, it may be necessary to override this requirement.

It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly where other people may be at risk. Where an adult refuses consent to share information, practitioners in all agencies must consider whether there is an overriding public interest of transferable risk that justifies information sharing regardless.

Information should be produced in a range of media for people with care and support needs and their carers. This should raise awareness, inform on process and facilitate complaints where required. Individuals must be informed of their right to an independent advocate.

Staff need to share a common understanding or what types of behaviour might be abuse or neglect. Staff must not second guess outcomes of enquiries and all agencies must have well publicised ways of staff escalating concerns if immediate managers do not take action in response to a concern being raised. Managers should provide skilled and knowledgeable supervision, ensuring high standards are achieved and that workers are supported.

Each agency must recognise and accept its role in relation to Adult Safeguarding and must promote a culture that is person-centred, that promotes prevention, early intervention and partnership working.
SECTION 47 – PROTECTING PROPERTY OF ADULTS BEING CARED FOR AWAY FROM HOME

This section applies where:

- An adult has needs for care and support in a way that involves the provision of accommodation, admission to hospital or both and
- It appears to the Local Authority that there is a danger of loss or damage to moveable property because the adult is unable (permanently or temporarily) to protect or deal with the property, and there is no one else available to make suitable arrangements
ADVOCACY

The Care Act 2014 requires that a Local Authority must arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has ‘substantial difficulty’ in being involved in the process and where there is no other appropriate individual to support them.

It should be noted therefore that this relates not only to people who have substantial difficulty as a result of lacking capacity (in accordance with the Mental Capacity Act 2005), but also to those who may not lack capacity, but may still have ‘substantial difficulty’ requiring support. Practitioners should be aware that the person concerned may have decisional capacity in the context of the Act, but the experience of abuse or neglect may have left them isolated, afraid or embarrassed, such that they would be at a disadvantage and an independent advocate may therefore be of benefit to them.

Where required, advocacy should be arranged as soon as the decision is made for a safeguarding concern to progress to a section 42 enquiry, although an advocate may be involved at an earlier stage. Sometimes it will not be known at the point of first contact or at an early stage whether there is someone appropriate to support the adult. In the event that an advocate is appointed and it is subsequently discovered there is an appropriate person available, the appointed advocate can at that point ‘stand down’. It is also possible that someone considered appropriate at the outset may subsequently experience difficulties in supporting the person concerned, or a conflict of interest may emerge – in such circumstances, arrangements for an appropriate advocate must be made as soon as this is recognised.

Independent Advocacy should be available to everyone who needs it, regardless of their age, gender, disability, sexuality or ethnicity. People should where possible, have choice over who acts as their advocate.
WHAT IS ADULT SAFEGUARDING?

“Protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.”


Safeguarding is NOT a substitute for:

- providers’ responsibilities to provide safe and high quality care and support
- commissioners regularly assuring themselves of the safety and effectiveness of commissioned services
- the Care Quality Commission (CQC)
- ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action
- the core duties of the Police to prevent and detect crime and protect life and property
- raising public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- providing information, advice and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult
- address what has caused the abuse or neglect

The aims of adult safeguarding are to:

- stop abuse or neglect wherever possible
- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- safeguarding adults in a way that supports them in making choices and having control about how they want to live
- promote an approach that concentrates on improving life for the adults concerned
WHAT IS ADULT SAFEGUARDING?

WHAT IS IT?

Any individual or agency can and indeed should raise a safeguarding alert if they are concerned that abuse or neglect is occurring, has occurred or may have occurred.

The Care Act places the statutory duty to coordinate the safeguarding response on the Local Authority. It also recognises however, that safeguarding is a multiagency responsibility and partnership work is vital to achieving successful outcomes.

The Care Act places a duty on the Local Authority to receive an alert and to decide whether a safeguarding enquiry is required or not. It then places a power on the Local Authority to delegate that enquiry to the agency most appropriate to carry it out. The Local Authority then retains the duty to quality assure the outcome of the enquiry and to decide what action needs to be taken as a result.

The six principles outlined within statutory guidance for safeguarding herald a change in practice for many professionals; a move away from the process-led, tick box culture that has sometimes dominated in the past, to a more person-centred approach which achieves the outcomes that people want – mindful of course of Public Interest issues and transferable risk.

Professionals must therefore have a flexible approach and work with the adult at the centre of their work throughout the enquiry and beyond, including in terms of supporting people to recover from abuse or neglect. Agencies should adopt the principle of ‘no delay’ in ensuring intervention is conducted in a timely manner.
PREVENTING ABUSE AND NEGLECT

MINIMISING THE LIKELIHOOD OF ABUSE

In accordance with Section 2 of the Care Act, the Local Authority must ensure provision of preventative services. Agencies should utilise strategies that support action before harm occurs, for example through robust and effective risk assessment and risk management that facilitates timely intervention. Examples of prevention strategies include:

- Identifying people at risk of abuse
- Inter-agency cooperation
- Raising public awareness
- Training and education
- Information, advice and advocacy
- Integrated policies and procedures
- Community links and support

Often, abuse or neglect can be prevented from occurring if issues are identified and responded to as soon as they arise with intervention at the earliest opportunity. This relies on people with care and support needs and those around them, having awareness of where to go and who they may be able to talk to for advice or support. It is therefore important they have access to clear information and advice.

Where an issue may not have reached the threshold for safeguarding intervention, advice and support may still be required. Appropriate sharing of information (with consent or in the public interest) helps to gather intelligence – it is important to remember that there may be other concerns that have been raised that you are not aware of. Reporting of concerns can enable serious abuse or harm to be prevented from happening or from continuing.

People working with adults with care and support needs in particular, have a responsibility to ensure they are aware of concerns, and know how and when to share these with relevant agencies, in the interests of preventing or reducing the risk of abuse or neglect, e.g. in relation to quality concerns around care and support services where there are implications for safeguarding.

Where abuse or neglect has occurred, steps must be taken to prevent recurrence wherever possible. Prevention should be considered at every step of a safeguarding process and should include focus on resilience and recovery.
Preventing Abuse and Neglect

Prevention in the Community

Organisations that provide housing, education, leisure and health and social care services will endeavour to make information about crime prevention available and accessible to service users, and where appropriate, support people to access services to enhance their safety.

Commissioners and regulators of services will ensure that those who provide services implement appropriate safeguards and responses to safeguarding issues.

Organisations should ensure all people known to pose a risk to others within the community (including those covered by the safeguarding policy), are where appropriate, referred for specialist multiagency risk management arrangements via Multi Agency Risk Assessment Conference (MARAC) or Multi Agency Public Protection Arrangements (MAPPA).

MARAC – Multi Agency Risk Assessment Conference

This is a multi-agency forum established for the purpose of managing high-risk cases of Domestic Abuse, stalking and ‘honour-based’ violence, i.e. those at risk of murder or serious harm.

It is a meeting where information is shared between representatives of local Police, Probation, Health, Children’s Services, Adult Social Care, Mental Health Services, Housing, Independent Domestic Violence Advisors (IDVA’s) and other specialists from the statutory and voluntary sectors.

The primary focus of MARAC is to safeguard the adult victim by sharing information and agreeing a risk focused, coordinated safety plan. At the heart of MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an Independent Domestic Violence Advocate (IDVA), or the referring practitioner who speaks on their behalf.

The purposes of MARAC are to:

- share relevant information about the victim, perpetrator and any children
- discuss options for increasing the safety of the victim and turn these into a coordinated action plan

A MARAC meeting is held once a month. An emergency MARAC can be called in discussion with the Chair. The meeting is coordinated and chaired by Police. An IT system called MODUS is used to securely store and share information about all MARAC referrals. Each agency who is a core participant of MARAC will have a Designated MARAC Officer (DMO) who has access to MODUS. For agencies that are not core participants
PREVENTING ABUSE AND NEGLECT

and wish to make a referral, the MARAC Administrator can be reached at this email address: BucksPVPMARAC@thamesvalley.pnn.police.uk.cjsm.net. For more information on MARAC see http://www.buckscct.gov.uk/media/130847/marac_leaflet.pdf.

If a practitioner identifies an individual is a victim of Domestic Abuse, they should complete a ‘Safe Lives’ DASH RIC (which can be accessed here: http://www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face) with the individual (practitioners should be trained in using this tool). This checklist will gather relevant information in order to assess the risk posed to them. Where an individual is assessed as being at high risk, the completed DASH RIC should automatically be shared with the organisations DMO in order to make a referral and agree any immediate safety actions.

Criteria for referral to MARAC

1. **Professional judgement** – if a professional has serious concerns about a victim’s situation, they should refer to MARAC. There will be occasions where the context of a case gives rise to serious concerns, even where the victim has been unable to disclose the information that might highlight their risk more clearly, e.g. extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers. This judgement would therefore be based on the professional’s experience and/or the victim’s perception of their risk even if they do not meet criteria 2 or 3.

2. **Visible high risk** – if the individual has met 14 or more of the outlined criteria on the DASH RIC, the case would normally meet the MARAC referral criteria. Where the criteria are not met, work will be undertaken by Police and other agencies outside of the formal MARAC process – this could include a referral under Adult Safeguarding.

3. **Potential escalation** – the number of Police callouts to the victim as a result of Domestic Abuse in the past 12 months. This criteria can be used where there is not a positive identification of a majority of the risk factors on the RIC, but where the abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC.

MAPPA – Multi Agency Public Protection Arrangement

MAPPA is not a statutory body in itself, but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a coordinated manner. Agencies at all times retain their full statutory
responsibilities and obligations. The purposes of MAPPA are to:

- ensure more comprehensive risk assessments are completed, taking advantage of coordinated information sharing across agencies
- direct the available resources to best protect the public from serious harm

The ‘Responsible Authority’ consists of the Police, Prison and Probation Trust working together. They have a Duty to ensure risks posed by specified sexual and violent offenders are assessed and managed appropriately. Other bodies have a Duty to cooperate with the Responsible Authority in this task. These other bodies will need to work with the Responsible Authority on particular aspects of an offenders life, e.g. education, employment, housing, social care.

Offenders eligible for MAPPA are identified and information is gathered about them across relevant agencies. The nature and level of risk they pose is assessed and a risk management plan is implemented to protect the public. In most cases, the offender will be managed under the ordinary arrangements applied by the agency or agencies with supervisory responsibility. Some though, require active multiagency management and their risk management plans will be formulated and monitored via MAPP meetings attended by various agencies.

There are 3 categories of offenders eligible for MAPPA:

**Category 1** – Registered sexual offenders; who are required to notify the Police of their name, address and other personal details and notify the police of any subsequent changes.

**Category 2** – Violent offenders; sentenced to detention for 12 months or more, or detained under hospital orders. This category also includes a small number of sexual offenders who do not qualify for registration and offenders disqualified from working with children.

**Category 3** – Other dangerous offenders; who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm. There is a link between the offending and the risk posed, and they require active multiagency management.
SUCCESSFUL PREVENTION REQUIRES THAT SERVICE PROVIDERS PROACTIVELY TACKLE THE FACTORS WHICH CONTRIBUTE TO THE OCCURRENCE OF ABUSE OR NEGLECT. IT ALSO REQUIRES COMMISSIONERS AND REGULATORS TO ENSURE STANDARDS WHICH PREVENT ABUSE AND NEGLECT ARE MET.

WHERE REGULATED CARE SERVICES ARE COMMISSIONED, AS A MINIMUM, EACH PARTNER WILL:

• HAVE A POLICY OF ‘ZERO TOLERANCE’ OF ABUSE OR NEGLECT WITHIN ITS ORGANISATION
• HAVE A SAFEGUARDING ADULTS POLICY, COMPATIBLE WITH THIS MULTIAGENCY FRAMEWORK
• HAVE CLEAR PROCEDURES FOR REPORTING, RECORDING AND MONITORING SERIOUS INCIDENTS, ACCIDENTS, HEALTH AND SAFETY ISSUES, VIOLENT AND CHALLENGING BEHAVIOUR AND ANY OTHER ISSUES AFFECTING CARE AND SUPPORT

• MAINTAIN CLEAR AND AVAILABLE PROCEDURES FOR RESPONDING TO ABUSE, INCLUDING REPORTING TO POLICE IF A CRIME IS SUSPECTED
• ESTABLISH AND ENFORCE CLEAR POLICIES AGAINST ANY FORM OF DISCRIMINATION OR HARASSMENT TOWARDS ANY PERSON
• HAVE A CODE OF CONDUCT IN PLACE FOR ALL STAFF AND VOLUNTEERS, SETTING OUT CLEAR STANDARDS FOR RELATIONSHIPS BETWEEN PEOPLE IN A POSITION OF TRUST AND SERVICE USERS, THAT IS COMPATIBLE WITH THE LAW AND REQUIREMENTS OF PROFESSIONAL REGULATORY BODIES

• HAVE CLEAR PROCEDURES FOR REPORTING, RECORDING AND MONITORING SERIOUS INCIDENTS, ACCIDENTS, HEALTH AND SAFETY ISSUES, VIOLENT AND CHALLENGING BEHAVIOUR AND ANY OTHER ISSUES AFFECTING CARE AND SUPPORT

• CARRY OUT REGULAR REVIEWS OF CRITICAL INCIDENTS NOT REFERRED UNDER SAFEGUARDING PROCEDURES AND WHERE APPROPRIATE, CARRY OUT ROOT CAUSE ANALYSIS

GOOD PRACTICE WITHIN HEALTH AND SOCIAL CARE SETTINGS WILL ENSURE EVERY SERVICE USER’S SUPPORT PLAN CONSIDERS POTENTIAL SAFEGUARDING ISSUES AND INCLUDES UP-TO-DATE RISK ASSESSMENTS SPECIFIC TO THE INDIVIDUAL. INCIDENTS OF ACTUAL OR POTENTIAL HARM SHOULD BE RECORDED AND, WHERE APPROPRIATE A REFERRAL MADE IN ACCORDANCE WITH SAFEGUARDING PROCEDURES. IN HEALTH SETTINGS, THIS MAY ALSO REQUIRE IMPLEMENTATION OF THE DEPARTMENT OF HEALTH PROTOCOL ON THE INVESTIGATION OF PATIENT SAFETY INCIDENTS INVOLVING UNEXPECTED DEATH OR SERIOUS UNTOWARD HARM – THIS IS HOWEVER, NOT A REPLACEMENT FOR THE SAFEGUARDING FRAMEWORK.
Commissioners and regulators will regularly audit reports of risk of harm and require providers to address any issues identified – where there is a series of minor incidents, root cause analysis may be required and this may meet a threshold for referral under the safeguarding framework.

In addition, commissioners will actively liaise with the SAB and regulatory bodies and monitor the ability of service providers to effectively safeguard users.
PREVENTING ABUSE AND NEGLECT

AWARENESS

Campaigns to raise public awareness can achieve considerable success. They are most successful when accompanied by information and advice about where to get help. Joint initiatives are often most effective.

Case study
Preventing abuse and neglect
PREVENTING ABUSE AND NEGLECT

INFORMATION / ADVICE

Information and advice is critical to the prevention agenda, and in terms of being able to seek help and support once it’s needed. All organisations should ensure they are able to provide information and advice about safeguarding, and that they are able to signpost people to receive the right kind of help from the right organisation.

Information and advice should include:

- How to raise a concern in relation to safeguarding
- Different types of abuse and neglect
- How to keep safe and how to support others to keep safe
- Safeguarding processes
- How the SAB works
Safeguarding intervention should be person-led and outcome focussed (mindful of course of public interest issues and transferable risk). It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Discussions should happen with the adult concerned at the earliest opportunity; enabling them to identify realistic outcomes so that their views, wishes, feelings and beliefs are central in decisions about how they wish to proceed. Discussions should continue throughout the process as their desired outcomes may of course change.

The very process of engaging with individuals can often give them a sense of control and self-esteem that enables them to better safeguard themselves. Some people may have no wish for any formal proceedings to be pursued and may be distressed when this happens without their knowledge or agreement. In complex domestic circumstances, it may take the adult some time to gain the confidence to take any action. Whilst most people do want to be safe, other outcomes may be as, or even more, important, e.g. maintaining relationships.

Safeguarding must respect the autonomy and independence of individuals and be mindful of their Human Rights and the importance of positive risk enablement and promoting independence.

Where it is necessary to proceed with an enquiry regardless of the expressed wishes of the individual concerned, due to public interest issues or transferable risk, this should be clearly explained to them along with a detailed rationale for the requirement. In the event you are unclear in this regard, please seek advice from the Safeguarding Lead within your own agency, or by contacting Safeguarding Adults Team on 0800 137 915.

Other people may be keen for a safeguarding response to provide access to some form of justice or resolution, such as; through criminal or civil law, restorative justice, via disciplinary action or similar. They may feel disappointed or let down if this doesn’t happen. The adult should be supported to understand the options available during an enquiry. Other approaches that may help to promote well-being, include therapeutic work, family work, mediation, conflict resolution, peer support or circles of support.

Case study
Making Safeguarding Personal (MSP)
PUBLIC INTEREST ISSUES AND TRANSFERABLE RISK

Where the person concerned has mental capacity to make the decision, and does not want their information shared, it may be acceptable not to share information pertinent to safeguarding matters with other partner agencies.

Exceptions to this principle of empowerment are:

1. Somebody else it at risk
2. A serious crime has been or may have been committed
3. The allegation involves an alleged perpetrator who is in a position of power of authority, e.g. a care worker or other Professional
4. Coercion or duress are suspected
5. The Public Interest of disclosure outweighs the principle of confidentiality
6. Risk of harm is high enough to warrant MARAC referral
7. Another Legal Authority has requested the information

In such cases, there remains a Duty to share information under the safeguarding framework and a decision may still be made to proceed with Sec 42 enquiry, dependent on the specific circumstances of the case in question.

Additional information on Information Sharing can be seen here.
WHO DO SAFEGUARDING DUTIES APPLY TO?

Statutory safeguarding duties apply to any adult who:

- has care and support needs, and
- is experiencing, or is at risk of, abuse or neglect and
- is unable to protect themselves from either the risk of, or the experience of abuse or neglect, because of those needs

These duties apply equally to all adults with care and support needs regardless of:

- whether or not they have the mental capacity to make decisions
- and regardless of where they live (other than prisons and approved premises)

The Care Act 2014 also recognises informal carers as people with support needs and therefore the safeguarding framework applies to them.

When someone is 18 or over but is still receiving children’s services and a safeguarding issue is raised, the matter will be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25.

Good practice will however ensure that Children’s Services play an active part in the intervention to ensure best outcomes are achieved for the individual concerned.

Allegations of historical abuse or neglect should be dealt with in exactly the same way as allegations of current situations. It is anticipated that the Yew Tree Enquiry will develop a specific protocol for dealing with historical allegations of sexual abuse specifically and this will be added to this policy when completed.
WHO IS MOST AT RISK?

Statutory safeguarding duties apply to any adult who:

- has care and support needs, and
- is experiencing, or is at risk of, abuse or neglect and
- is unable to protect themselves from either the risk of, or the experience of abuse or neglect, because of those needs

Abuse or neglect can happen anywhere; for example, in someone's own home, in a public place, in a hospital or care home or educational setting. It can take place when an adult lives alone, or when they live with others.

Whilst a lot of publicity is attached to, for example, targeted fraud or internet scamming, it is more likely that the person responsible for abuse or neglect will be known to the person concerned, and may perhaps be in a position of power.
BSAB requires workers in all organisations and settings to be vigilant for adult safeguarding concerns. This includes statutory agencies, but also the public sector, voluntary organisations and the wider community.

This will include ensuring people:

- know about the different types of abuse and neglect
- support adults to keep safe
- know who to tell about suspected abuse or neglect
- support adults to consider the risks and benefits of different options and make sure they have access to advice and information to make informed decisions when exercising principles of choice and control
- are alert to situations where the individual lacks capacity and will require support from an advocate in relation to concerns about abuse or neglect
- are aware of when to act without consent in terms of the Public Interest or transferable risk

Awareness campaigns for the wider community and multiagency training for all staff will contribute to achieving these objectives.

**Case study**

Spotting signs of abuse and neglect
WHAT TO DO IF YOU SUSPECT ABUSE

If someone discloses abuse or neglect to you:

- stay calm and try not to show you are shocked
- listen carefully rather than question the discloser directly
- be empathetic
- be aware that medical and criminal evidence may need to be preserved – do not attempt to remove torn or soiled clothing and avoid touching or moving anything in the immediate environment
- follow your agencies internal policies and procedures but in the absence of being able to consult your line manager or delegated person, speak to Police or the Safeguarding Adults Team for advice

The first priority should always be to ensure the immediate safety and wellbeing of the adult concerned and any other people.

Wherever there may be an immediate serious or life threatening risk to someone, emergency services should be contacted. Steps should also be taken to preserve evidence, whether that be forensic evidence or other forms of evidence. Care should be taken not to contaminate any potential criminal enquiry – if in any doubt as to whether criminal proceedings may follow seek urgent advice from either the Police or Safeguarding Adults Team.

The agency identifying or receiving the concern should write down what was seen if the incident was witnessed, or what was said if a disclosure was made. Exact words or phrases should be used wherever possible. The setting and anyone present at the time should be noted, including any significant points about the person concerned appearance, demeanour and mood, and about the environment, e.g. if furniture is disturbed, property is missing or damaged.

Recording should be clear about what is fact, versus what is opinion. Each agency should have internal policies and procedures, which include practices such as using a body map to illustrate any physical injury, the location of any wounds or bruises and their size, colour etc., and also the use of photographic images to record evidence. If taking photographs, it is vital to be mindful of issues around capacity and consent, and for any decision taken in the absence of capacity to be done in the best interests of the person concerned.

Practitioners should be mindful of using personal equipment to record images as should criminal proceedings follow,
WHAT TO DO IF YOU SUSPECT ABUSE

personal equipment may be required as evidence and therefore not returned until the case is concluded. If in any doubt, advice should be sought from Police or Safeguarding Adults Team.

The views of the person concerned and their desired outcomes should be obtained in order to make a decision about making a referral. In the event that the person concerned does not consent, but it is in the Public Interest or there is transferable risk, the practitioner will need to tell the person concerned they have a Duty to make a referral regardless.

If a safeguarding concern needs to be reported to the Safeguarding Adults Team, this should be done immediately where the concern is urgent and serious, or at least within the same working day for any other concerns. The Safeguarding Adults Team can be reached on 0800 137 915 or an alert form can be completed here. Where a professional is making the referral, they should complete the alert form with as much relevant detail as possible so as to help effective and timely decision making. The referral should include whether it is being made with consent, or if not, why consent was not given and overrode.

The agency concerned should ensure they have fully documented the incident and any actions taken. Dark ink should be used to record notes, so that they can be photocopied if required. Everything should be signed and dated, in case it is required as evidence subsequently. Records should be contemporaneous, i.e. made as soon as possible after the event.

Key people should be notified, including any regulatory body. Support should be provided to any involved persons.

To understand what happens to the safeguarding concern once it has been referred to the Local Authority please see Buckinghamshire County Council Adult Safeguarding Procedures.
PRISONS AND APPROVED PREMISES

Prison Governors and National Offender Management Services (NOMS) have responsibility for safeguarding within prisons and approved premises. They may make approaches to the Local Authority for advice and assistance in individual cases, but the Local Authority will not have the legal duty to manage enquiries in any custodial setting.

Senior representatives of prisons and approved premises may be members of Safeguarding Adults Boards and play an important role in the context of strategic development around safeguarding.
CARERS

The Care Act recognises the key role of informal carers with regard to safeguarding. Section 1 of the Care Act includes protection from abuse as part of the definition of wellbeing and assessment of both the carer and the adult they care for must therefore include consideration of this.

Circumstances in which a carer could be involved in a situation that may require a safeguarding response includes when:

- a carer may witness of speak up about abuse or neglect
- a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals or organisations they are in contact with
- a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others

If a carer speaks up about abuse or neglect, it is essential they feel listened to and the appropriate response is given and explained.

Consideration should be given to support which mitigates against abuse occurring, The carer may require independent representation or advocacy, either due to a conflict of interest if they are under great stress. Other agencies should be involved in some circumstances. Where a criminal offence is suspected, this will include alerting the Police.

Work developed by ADASS, carers groups, commissioners and other organisations working with carers has identified six main areas relating to carers and safeguarding. These are:

1. Partnership working
2. Prevention
3. Support
4. Information and Advice
5. Advocacy
6. Role of carers in strategic planning

Case study
Carers and safeguarding
Organisations should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual should always be considered. The following illustration of abuse and abusive behaviours is therefore not exhaustive and has been included for guidance only.

- Physical
- Domestic Abuse
- Sexual
- Psychological
- Financial or material
- Modern slavery
- Discriminatory
- Organisational
- Neglect and acts of omission
- Self-neglect

Additional areas of abuse to be considered:

- Female Genital Mutilation
- Forced Marriage
- Honour Based Abuse
- Cyber Bullying
- Internet Crime/Abuse
- Hoarding
- Hate Crime
- Anti-Social Behaviour
- Prostitution and Adults at Risk
- Personal Budgets and Self-directed Care
How to Report Safeguarding Concerns

3 Step Guide

1. MAKE SAFE
   - If emergency services are required Call 999
   - Take reasonable steps to ensure that there is no immediate danger
   - Protect evidence

2. NOTIFY
   - Your manager
   - Or more Senior Manager if there is a conflict of interest or manager is unavailable
   - Directly to Safeguarding Adults Team if appropriate

3. REFER
   - Is the person an adult at risk from abuse, neglect or self-neglect?
     - YES
     - Refer without delay to Safeguarding Adults Team
     - Record decision making
     - Refer to appropriate agency to address any remaining concerns
     - Record decision making
     - NO

Who to contact for advice or to make a referral

Concerns about an Adult
Safeguarding Adults Team
Tel: 0800 137 915
Email: safeguardingadults@buckscc.gov.uk

Concerns about a Child
First Response
Tel: 0845 460 0001
Email: cypfirstresponse@buckscc.gov.uk

Concerns out of hours
Out of hours, emergency duty team
Tel: 0800 999 7677

Your organisation’s Safeguarding Lead
Tel: 0800 137 915

MULTI AGENCY PROCEDURES

CONTACT DETAILS IN BUCKINGHAMSHIRE

Safeguarding Adults Procedures

Raising a concern regarding an adult
If the concern is urgent, and the adult is at immediate risk of harm dial 999. Report immediately to your manager, before contacting the Safeguarding Adults team

Tel: 0800 137 915
Email: safeguardingadultsfr@buckscc.gov.uk

Outside normal working hours
Contact the Emergency Duty Team (EDT):

Tel: 0800 999 7677
Email: ooheswt@buckscc.gov.uk

Raising a concern regarding a child
Contact First Response

Tel: 0845 460 0001
ROLES AND RESPONSIBILITIES

OVERVIEW OF WHO MIGHT BE INVOLVED IN ADULT SAFEGUARDING AND WHAT THEIR ROLE MIGHT BE

» LOCAL AUTHORITY
» SAFEGUARDING ADULTS TEAM
» LOCAL AUTHORITY DESIGNATED OFFICER (LADO)
» THAMES VALLEY POLICE (TVP)
» CLINICAL COMMISSIONING GROUP (CCG)
» CORONER
» ADVOCATES
» PROVIDER ORGANISATIONS
» BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD
» MULTI AGENCY SAFEGUARDING HUB (MASH)
» ALL PARTNER AGENCIES
LOCAL AUTHORITY

The Local Authority has the legal Duty to coordinate the safeguarding response. This means the Local Authority has a Duty to receive the concern and to decide whether a Sec 42 Enquiry is required or not. It then has a Power to delegate this enquiry to the individual or organisation is considers best placed or most appropriate. The Local Authority then retains the legal Duty to review the Enquiry upon completion, both to quality assure it’s content and outcomes and to determine what actions may be required as a result of it.
SAFEGUARDING ADULTS TEAM

The Safeguarding Adults Team acts as the first point of contact for ALL safeguarding concerns in Buckinghamshire except for in an emergency situation, wherein 999 should be called. The Multiagency Safeguarding Hub (MASH) co-locates key partners in order to improve the initial response to safety concerns. MASH is staffed by safeguarding professionals from; Bucks County Council, Thames Valley Police and Bucks Healthcare Trust, who work from Aylesbury Police Station. Mash can be contacted on 0800 137 915 during normal working hours, or via 0800 999 7677 outside of these.

Upon receipt of a concern into the MASH, information will be collated to build up a picture of the circumstances of the person(s) subject to the concerns and in order to assess whether intervention under the safeguarding framework is required. This will include discussion with the person concerned in order to establish their consent to the process (if this has not already been done) and their desired outcomes – unless to do so, would put them in additional or increased danger.

MASH has replaced a range of existing referral points and allows agencies to work together more closely than previously and ensures a timely and consistent response for all safeguarding concerns. Staff within MASH also provide information, advice and guidance for professionals and the general public, helping improve the quality of information provided and the number of inappropriate referrals.
LOCAL AUTHORITY DESIGNATED OFFICER (LADO)

Please refer to section on Safeguarding Children
THAMES VALLEY POLICE (TVP)

TVP are statutory members of the BSAB. Many forms of abuse or neglect may amount to criminal offences.

Whilst Safeguarding is everyone’s business; prevention, identification, investigation, risk management and detection of criminal offences is a fundamental role of the Police.

Criminal Investigations will take precedence over other forms of enquiry, but safeguarding planning will need to be undertaken in parallel. The Police coordinate criminal investigations with wider safeguarding responses – this requires partnership, effective communication and co-operation, making best use of each organisation’s skills and expertise in order to achieve safe, affective and timely outcomes for those at risk.
The ‘NHS Accountability and Assurance Framework 2015’ sets out the framework for Adult Safeguarding within the Health Service. It clearly sets out roles, duties and responsibilities of agencies commissioning NHS health care. It does not generate new policy or priorities, but articulates how the performance of the wider NHS, with respect to duties and priorities defined elsewhere, will be delivered and assured.

The CCG is the statutory partner of the BSAB. The CCG is the commissioner of local health services and needs to assure itself that the organisation’s from which they commission, have effective safeguarding arrangements in place. CCGs are responsible for securing the expertise of Designated Professionals, on behalf of the local health system. Designated Professionals and Adult Safeguarding Leads, undertake a whole health economy role – it is crucial they play an integral role in all parts of the commissioning cycle, from procurement to quality assurance if appropriate services are to be commissioned that support those at risk of abuse and neglect, as well as effectively safeguarding their well-being.

Assessment may consist of assurance visits, section 11 audits and attendance at provider safeguarding committees. CCGs are also required to demonstrate they have appropriate systems in place for discharging their statutory duties in terms of safeguarding.

This framework can be seen here
Coroners enquire into the deaths reported to them. It is their role to establish cause of death if it’s not known, and to enquire about the cause if due to violence, or otherwise appears unnatural. Any situation where it is thought abuse or neglect may have contributed to or resulted in death, must be referred to the coroner at the earliest opportunity. Likewise, where it is anticipated someone is likely to die as a result of abuse or neglect, this should also be reported to the coroner at the earliest opportunity. This will enable the coroner to make investigation, post mortem and inquest decisions in a timely fashion.

In addition, referral to the coroner must be made in the following circumstances:

- A death that occurs during a Sec 42 enquiry
- A death that occurs within 30 days of a Sec 42 enquiry being completed
- When a large scale enquiry is started – this will alert the coroner to services about which there are significant concerns
- Any service wherein it is identified there appears to be a high death rate

The coroner will also inform the Safeguarding Adults Team of any deaths they consider may be due to safeguarding concerns or any unusually high death rate, to inform decisions about whether a Sec 42 enquiry, large scale enquiry, or safeguarding adults review is required.
Where a person is unable to understand the information given to them, or to retain or use that information, or communicate their views, wishes or feelings even with support, they lack mental capacity. IMCAs can provide a form of non-instructed advocacy for people who lack mental capacity. Their role was established by the Mental Capacity Act 2005.

The local authority will need to consider whether to instruct an IMCA in the event that an adult at risk lacks mental capacity in relation to safeguarding measures required within the safeguarding adults procedure.

Safeguarding measures may include (but are not limited to):
- Restrictions on contact with certain people.
- Temporary or permanent moves of accommodation.
- Increased support or supervision.
- An application to the Court of Protection.
- Restrictions on accessing specific services and / or places.
- Access to counselling or psychology with the aim of reducing the risk of further abuse.

The local authority or NHS body may instruct an IMCA to represent the person concerned if it is satisfied that there would be a ‘particular benefit’ for the person.

The role of the IMCA includes:
- Finding out wherever possible the person’s wishes, feelings, values and beliefs.
- Representing the person’s best interests.
- Promoting consideration of the least restrictive option.
- Supporting the person through the decision making process as an independent person.
- Safeguarding the rights and entitlements of the person as set out in the Mental Capacity Act, ensuring that the basic principles and the best interest checklist are being followed.
- Challenging where appropriate, the decision on behalf of the adult at risk.

In safeguarding adults cases, access to IMCAs is not restricted to people who have no one else to support or represent them. Therefore, people who lack mental capacity who have family and friends can still have an IMCA to support them through the safeguarding adults procedure. Local guidance may apply.
Independent Mental Health Advocacy is a statutory form of advocacy which was introduced in 2009 as part of amendments to the Mental Health Act. Anyone who is detained in a secure Mental Health setting, under the Act, is entitled to access support from an Independent Mental Health Advocate (IMHA).

IMHA services provide an additional safeguard for patients who are subject to the Mental Health Act, and are specialist advocates who are trained to work within the framework of the Act. These services will not replace other advocacy services currently available to patients, but are intended to operate in conjunction with them.

Where an individual needs an advocate to support them though an adult safeguarding concern an independent advocate rather than an IMHA may be appropriate.
INDEPENDENT ADVOCATES (SUBSTANTIAL DIFFICULTY)

Where an adult at risk has mental capacity but they have a ‘substantial difficulty’ being involved in the process, and they have no one other than those acting in a professional capacity to support them, it is necessary to consider if there is a ‘particular benefit’ to providing them with an independent advocate. Where the provision of an independent advocate is appropriate and proportionate to the circumstances, the local authority must arrange for one to be provided. ‘Substantial difficulty’ does not mean the person cannot make decisions for themselves, but refers to situations where the adult at risk needs support to understand the information given to them, or support to retain or use that information, or support to communicate their views, wishes or feelings.

The support provided by the independent advocate will depend on the needs and wishes of adult at risk. Independent advocates will take their direction from the adult at risk. Independent advocates will ordinarily be invited to relevant meetings, either accompanying the adult at risk or attending on their behalf, according to the wishes of the adult at risk. If the adult at risk is unable to make decisions even with support, they lack mental capacity and the need for an Independent Mental Capacity Advocate should be considered instead.
Community, voluntary and private sector organisations will provide a diverse range of services to adults at risk. Each organisation will have an important role within this safeguarding adult’s procedure and provide services that will assist in both preventing and responding to abuse. Community, voluntary and private sector organisations will need to work closely with statutory agencies, such as the police, NHS and adult social care, in the interests of adults at risk and to achieve the objectives of this procedure. The role of community, voluntary and private sector organisations will depend on the nature of the service provided.
The main objective of the BSAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out at paragraph. The BSAB has a strategic role that is greater than the sum of the operational duties of the core partners. It oversees and leads adult safeguarding across the locality and will be interested in a range of matters that contribute to the prevention of abuse and neglect. These will include the safety of patients in its local health services, quality of local care and support services, and awareness and responsiveness of further education services. It is important that BSAB partners feel able to challenge each other and other organisations where it believes that their actions or inactions are increasing the risk of abuse or neglect.

This will include commissioners, as well as providers of services.

A BSAB has three core duties:

1. It must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the BSAB must consult the local Health watch organisation.

2. It must publish an annual report detailing what the BSAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action.

3. It must conduct any Safeguarding Adults Review in accordance with Section 44 of the Act. Safeguarding requires collaboration between partners in order to create a framework of inter-agency arrangements. Local authorities and their relevant partners must collaborate and work together as set out in the co-operation duties in the Care Act and, in doing so, must, where appropriate, also consider the wishes and feelings of the adult on whose behalf they are working those adults who have been involved in a safeguarding enquiry.

For further information please refer to sections 14.104-14.149 of the statutory guidance Care & Support Statutory Guidance.
BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD

BOARDS MUST WORK IN PARTNERSHIP

- LOCAL AUTHORITY
- SAFEGUARDING ADULTS TEAM
- LOCAL AUTHORITY DESIGNATED OFFICER (LADO)
- THAMES VALLEY POLICE (TVP)
- CLINICAL COMMISSIONING GROUP (CCG)
- CORONER
- ADVOCATES
- PROVIDER ORGANISATIONS
- BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD
  - Boards must work in partnership
  - Joint systems
  - Safeguarding Adult Reviews
- MULTI AGENCY SAFEGUARDING HUB (MASH)
- ALL PARTNER AGENCIES

Raising a concern form
Each partner agency will have its own internal ‘safeguarding adults’ procedural guidelines, which should be consistent with the multi-agency policy and procedure, and clearly describe the responsibilities of all of the workers who operate within them.

Where appropriate, those partner agencies who perform such functions should also agree to integrate assessment tools which identify risk of abuse and neglect into their assessment practice and risk management protocols, and adopt a process for carrying out an annual audit of cases concerning the abuse of service users.

In addition, each partner organisation should ensure that its staff and volunteers at all levels, as well as any students on placement, have access to relevant information and training, and have the necessary knowledge and skills to enable them to fulfil their individual roles in relation to safeguarding work.

All workers, whether paid or voluntary should know who they can contact to report concerns of risk of abuse or neglect.

Regular recorded supervision for staff and volunteers too, should address safeguarding adults issues (sometimes to discuss practice in specific cases) and – along with the appraisal process - identify related training needs.

Where services are commissioned by statutory public agencies, the same standards should be applied. Commissioning and Contracts Officers should monitor individual services to ensure compliance with this policy and procedural framework.
SAFEGUARDING ADULT REVIEWS

BSAB must arrange a SAR 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.

BSAB must also arrange a SAR if an adult in its area has not died, but BSAB 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. BSAB is free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

BSAB should be primarily concerned with weighing up what type of ‘review’ process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.

SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

To understand the global role of the SAB, see here.
MULTI AGENCY SAFEGUARDING HUB (MASH)

What is the MASH?
The Buckinghamshire Multi-Agency Safeguarding Hub (MASH) co-locates key partners in order to improve the initial response to safeguarding concerns in relation to children and vulnerable adults. The role of the MASH is for information only; this is an internal process that may occur following a professional or a member of the public making a safeguarding referral regarding an adult or child in the usual manner.

Tel: 0800 137 915

Bringing together key partners and forging stronger links with other agencies enables information to be shared quickly and effectively and better informed decisions to be made by social care. This approach will assist in identifying risk at an earlier stage and result in appropriate early intervention in order to safeguard vulnerable children and adults.

What are the benefits of MASH?
Co-locating key safeguarding agencies in a MASH enables:

- Earlier identification of risk
- A more coordinated response
- Appropriate early intervention, resulting in longer term benefits for children, vulnerable individuals and partner agencies.

Safeguarding professionals from Buckinghamshire County Council (children’s and adult’s services), Thames Valley Police and Buckinghamshire Healthcare Trust will be working together from Aylesbury Police Station. They will access their respective organisation’s systems and share relevant information in a secure environment. The MASH will also seek information from other agencies across both the public and voluntary sectors.

- ROLES AND RESPONSIBILITIES
- LEGISLATION AND GUIDANCE
- RECORD KEEPING AND SHARING
- CASE STUDIES
- FORMS
-GLOSSARY
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» LOCAL AUTHORITY
» SAFEGUARDING ADULTS TEAM
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» PROVIDER ORGANISATIONS
» BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD
» MULTI AGENCY SAFEGUARDING HUB (MASH)
» ALL PARTNER AGENCIES
Each partner agency will have its own internal safeguarding procedure, which should comply with the multiagency framework, and should clearly set out the responsibilities of all persons who operate within them. Policies & Procedures must include:

- Statement if purpose relating to promoting wellbeing, preventing harm and responding effectively if concerns are raised
- Statement of roles and responsibilities, authority and accountability, specific enough to ensure all personnel understand their role and limitations
- Statement of process for dealing with safeguarding concerns, including for emergency situations and reporting to Police when appropriate
- Full information on how to make a referral, whether inside normal working hours or not, including comprehensive list of contact details both locally and nationally
- Information on how to record allegations, enquiries and all associated work.
- Full description of channels for multiagency communication and procedures for information sharing and decision making
- Details of how Professional disagreements are to be resolved, especially with regard to disagreements about whether a referral should be made or not.

Procedures should be updated to incorporate learning from published research, peer reviews, case law and Safeguarding Adults Reviews. Where appropriate, partner agencies should agree to integrate assessment tools, which identify risk of abuse and neglect, into their assessment practice and risk management protocols, and adopt a process for carrying out annual audit of cases concerning safeguarding.

Each partner agency should ensure its staff and volunteers at all levels have access to relevant information and training and have the necessary knowledge and skills to enable them to fulfil their individual roles in relation to safeguarding work.

All personnel within partner agencies should know who they can contact to report concerns of abuse or neglect, including how to access and follow whistleblowing protocols.

Regular supervision of staff and volunteers should address safeguarding concerns and identify related training needs.
LEGISLATION AND GUIDANCE

KEY LEGISLATION AND GUIDANCE UNDERPINNING THE SAFEGUARDING OF ADULTS

» TYPES OF ABUSE
» THE CARE ACT 2014
» MENTAL CAPACITY AND DEPRIVATION OF LIBERTY
» GAINING ACCESS TO ADULTS AT RISK
» SAFEGUARDING ADULTS AND HUMAN RIGHTS
» DISCLOSURE AND BARRING
» HEALTH AND SOCIAL CARE ACT 2008
» THE ROLE OF THE CRIMINAL JUSTICE SYSTEM
» MANAGING ALLEGATIONS AGAINST STAFF AND VOLUNTEERS WORKING WITH ADULTS
TYPES OF ABUSE

PHYSICAL ABUSE

Examples of physical abuse include; assault, hitting, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Inadvertent physical consequences arising from poor care or support, e.g. bruising arising from poor moving and handling with usually be categorised as ‘neglect’. Concerns around quality of care will not usually be addressed under safeguarding procedures, unless there is a direct impact on the person concerned.

Indicators of physical abuse are often evident, but they may also be hidden by either the abuser or the person concerned. All unexplained injuries should always be fully looked into.

There is a distinction to be drawn between restraint, restriction and deprivation of liberty. Unlawful or inappropriate use of restraint or physical interventions and/or deprivation of liberty is physical abuse. In extreme circumstances this may constitute a criminal offence. Someone is using restraint if they use force, threaten to use force, make someone do something they are resisting, or where a person’s freedom of movement is restricted (whether or not they are resisting).

Restrain covers a wide range of actions, including both active and passive means to ensure the person concerned does something they don’t want to do, or does not do something they want to do.

Restrictive interventions are only justified where they are used in the best interests of the person concerned, and mindful of the need to protect the safety of others. Where restrictions are necessary, the less restrictive approach should always be used. If the person concerned lacks capacity in this context, any interventions must accord with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards Code of Practice.

Female Genital Mutilation (FGM) is also considered as physical abuse.

Physical harm resulting from abuse or neglect may constitute a criminal offence such as assault, battery, manslaughter or murder. See Legal Framework for physical abuse.
Female Genital Mutilation (FGM)
This involves procedures that intentionally alter or injure female genital organs for non-medical reasons. There are no health benefits to the procedure for either girls or women. The Female Genital Mutilation Act 2004 makes it illegal to practice FGM in the UK or to take girls who are British Nationals or permanent residents of the UK abroad, for FGM, whether or not it is lawful in another country.

Legal Framework for physical abuse

Assault
This term is commonly used to refer to a physical attack. However, common assault occurs when a person ‘intentionally or recklessly causes somebody else to apprehend or anticipate any immediate and unlawful violence or touching’. (R v Savage [1991] AC 699 (House of Lords).

Battery
This term is used when a person intentionally or recklessly applies unlawful force to somebody else, i.e. ‘intentional touching of another person without the consent of that person and without lawful excuse. It need not necessarily be hostile, rude or aggressive’. (Faulkner v Talbot [1981] 3 All ER 468 (Court of Appeal).

Assault and Battery
This may be applied to injuries such as grazes, scratches, abrasions, minor bruising, swelling, reddening of the skin, superficial cuts or a black eye (CPS).

Examples of practices in the context of ‘people with care and support needs’ which may lead to prosecution for assault and battery include the following (taken from Mandelstam, M (2013) ‘Safeguarding Adults and the Law’ 2nd Edition)

• retired nurse for ripping her mother’s clothes, spitting, screaming and elbowing her
• a former support worker, now working as a barber, shaving the word ‘fool’ into the hair of a person with learning disabilities
• a care assistant bending back the thumbs of residents as part of the way she handled them
• a nurse stuffing deodorant into the mouth of an older person to stop them shouting
• a care worker throwing a cup of tea at a resident
TYPES OF ABUSE

PHYSICAL ABUSE

- staff slapping, kicking or mishandling people with care and support needs

Assault occasioning bodily harm
Under s.47 of the Offences against the Person Act 1861. An offence distinguished from common assault by the degree of injury resulting (CPS). This could include for example an act that results in the person concerned losing or breaking a tooth/teeth, (temporary) loss of sensory functions including consciousness, extensive or multiple bruising, displaced/broken nose, minor fractures, minor cuts (not superficial) or psychiatric injury beyond fear, distress or panic.

Unlawful wounding or grievous bodily harm
Under s.20 of the Offences against the Person Act 1861. This relates to wounds in the context of more serious cuts or lacerations and serious bodily harm, for example; permanent disability or permanent loss of sensory function, permanent disfigurement, significant broken bones, compound fractures, substantial blood loss or injuries resulting in lengthy treatment or incapacity.

Administering a Poison or Noxious Thing
s.23 and 24 of the Offences against the Person Act 1861. This makes it an offence to administer unlawfully or maliciously any poison or other noxious thing either with the effect of endangering life or including grievous bodily harm, or with the intention of injuring, aggrieving or annoying the person concerned. An example of this may be a person working in a care setting administering one or more drugs in order to inappropriately sedate someone for convenience or personal gain.

False Imprisonment
Common law offence involving unlawful and intentional or reckless detention of a person. Refer to DoLS Guidance and Code of Conduct for further information on authorised deprivation of liberty.

Manslaughter
Can be voluntary or involuntary. Involuntary manslaughter may be an unlawful act or through gross negligence or recklessness. A charge of murder may be reduced to voluntary manslaughter on the grounds of diminished responsibility, provocation or acting in pursuance of a suicide pact (see Homicide Act 1957, ss 2-2).

Corporate Manslaughter
Within organisational settings, there may be cause to prosecute gross negligence or recklessness in care. Individual employees, frontline staff or managers
TYPES OF ABUSE

PHYSICAL ABUSE

may be prosecuted under common law. Alternatively, the organisation itself can be prosecuted under the Corporate Manslaughter and Corporate Homicide Act 2007.

Murder

A person of sound mind unlawfully killing a human being with intent to kill or cause grievous bodily harm.

Attempted Murder

s.1 of the Criminal Attempts Act 1981 relates to a charge of attempted murder where a person of sound mind undertakes an act that goes beyond being purely preparatory to murder, with an intention to kill.

Ill-treatment or wilful neglect

Are criminal offences which apply to any setting in relation to care of people who lack mental capacity or have a mental disorder (Mental Capacity Act 2005 and Mental Health Act 1983). The Court of Appeal has stated that recklessness applies to the context, as well as any deliberate failure to do something that was a Duty.

Case study 1

Criminal offices and adult safeguarding

Case study 2

Criminal offices and adult safeguarding
The cross-government definition of Domestic Violence and Abuse is: ‘any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality’ (Home Office, 2013). Concerns of Domestic Abuse where the young person is aged 16 or 17 would be dealt with under Children Protection procedures.

The abuse can include, but is not limited to: psychological, physical, sexual, financial or emotional contexts. Common features where Domestic Abuse is occurring are the presence of Coercion and Control.

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

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

Domestic Abuse also includes Forced Marriage and ‘Honour Based’ Violence.

There are a range of legal remedies available to support in the protection of victims of Domestic Abuse. Specialist Support Services and Police will be able to provide context specific advice.

Legal Remedies for Domestic Abuse

Domestic Violence Protection Order

If Police have a reasonable belief that Domestic Abuse has occurred, they can serve a Domestic Violence Protection Notice, if authorised by a Superintendent or higher. The Police then need to apply to a court for a Domestic Violence Protection Order, which if granted will apply for between 14 and 28 days. It may stop the perpetrator from entering or being within a certain distance of the home, stop the perpetrator making the person at risk leave their home or require the perpetrator to leave their home.

Restraining Order

Can be made by a court in relation to criminal cases alleging Domestic Abuse, whether or not the case is upheld. It is made when there is a need to protect
TYPES OF ABUSE

DOMESTIC ABUSE

a named person or persons from harassment or conduct that will put them in fear of violence. It imposes prohibitions and may cover a range of behaviour. It is preventative, not punitive, but breaking this is a crime.

Forced Marriage Protection Order
This can be made by a designated court, but a person at risk or a 3rd party and a Local Authority can make an application for adults with care and support needs. It can prohibit a marriage, demand to reveal the whereabouts of a person and ensure the security of passports and travel documents.

Non-molestation order
This prevents the abuser from certain behaviour or compels them into action. A power of arrest can be attached to this.

Occupation order
This establishes who has the right to stay within the home. It can order an abuser to move out or to keep a certain distance from the home.

Common Law / Assault & Trespass Injunction
This can stop somebody who does not live in the property, such as a relative or acquaintance, entering the property, and from harassing or assaulting them.

Anti-harassment Injunction
This can be used if the person is being continually harassed, threatened, pestered or stalked by a stranger, acquaintance, or after a relationship has ended.
Forced Marriage is a term used to describe a marriage in which one or both parties are married without their consent and against their will. This differs from an arranged marriage, in which both parties consent to the assistance of a third party in identifying a spouse.

In a situation where there is concern that an adult is being forced into a marriage they do not or cannot consent to, there will be an overlap between action taken under the forced marriage provisions, and the safeguarding adults process.

The Anti-social Behaviour, Crime and Policing Act 2014 makes it a criminal offence to force someone to marry.

For further specialist information and advice, contact:

- Karma Nirvana
- Forced Marriage Unit
TYPES OF ABUSE

DOMESTIC ABUSE - ‘HONOUR BASED’ ABUSE

‘Honour Based’ Abuse
‘Honour Based’ abuse is a crime and should be reported to the Police. It occurs in circumstances where a family or community feel that dishonour has been brought to them. Both women and men can be victims and the violence is often committed with a degree of collusion from family members and/or the community. Whilst some victims will contact the Police, many are so isolated and controlled that they are unable to seek help.

For further specialist information and advice, contact:

- Karma Nirvana
- Victim Support
- Honour Based Violence Awareness Network
**TYPES OF ABUSE**

**SEXUAL ABUSE**

Examples of sexual abuse include: rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the individual has not consented or was pressured into consenting.

It is important to remember that all concerns relating to delayed reporting or historical sexual abuse should be responded to with the same rigour as if it was a current situation.

There are specific sections of the Sexual Offences Act 2003, concerning criminal offences in relation to people who have a mental disorder or lack the mental capacity to consent to sexual acts or relationships – refer to the legal framework for more information.

**Sexual Abuse Legal Framework**

The Sexual Offences Act 2003 reformed the law on sexual offences. In addition to the basic offences applicable to the general population, this introduced three sets of offences specifically related to victims with a mental disorder, with special rules attached – of these three; two do not require that the victim lacked capacity to consent to the sexual activity.

**Rape**

Consists of (a) intentional penetration of the vagina, anus or mouth of the victim with the penis, (b) lack of consent and (c) the perpetrator does not reasonably believe that the victim consents.

**Sexual Assault or Causing Sexual Activity without Consent:**

**Assault by Penetration**

Consists of (a) intentional penetration of the vagina or anus with a part of the perpetrator’s body or anything else, (b) the penetration being sexual, (c) lack of consent and (d) the perpetrator does not reasonably believe that the victim consents.

**Sexual Assault**

Consists of (a) intentional touching of another person, (b) the touching being sexual, (c) lack of consent and (d) the perpetrator does not reasonably believe the victim consents.

**Causing sexual activity without consent**

Consists of (a) intentional causing of another person to engage in an activity, (b) the activity being sexual, (c) lack of consent and (d) the perpetrator does not reasonably believe the victim consents.

In addition, the following offences (found in sections 30-33 of the Sexual Offences Act 2003) specifically relate...
Sexual activity in the context of these offences is defined as “touching involving, (a) penetration of the victim’s anus or vagina with a part of the perpetrator’s body or anything else, (b) penetration of the victim’s mouth with the perpetrator’s penis, (c) penetration of the perpetrator’s anus or vagina with a part of the victim’s body or (d) penetration of the perpetrator’s mouth with the victim’s penis.

The inability to refuse must be because either:

- the victim ‘lacks capacity to choose whether to agree to the touching’ or
- ‘is unable to communicate their choice’

Offences under sections 30-33 of the Act also rely on the perpetrator knowing, or reasonably being expected to know, of the mental disorder, and that because of it, or a reason related to it, the victim was likely to have ‘been unable to refuse’.

A further group of offences, under sections 34 – 37 of the Act, do not require that the mentally disordered victim lack capacity to decide. They do still require the perpetrator to know, or reasonably be expected to know, that the victim has a mental disorder.

These offences concern inducement, threat or deception to:

- Procure sexual activity with a person with a mental disorder
- Cause the person with a mental disorder to engage in sexual activity by inducement, threat or deception
- Engage in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder
TYPES OF ABUSE

SEXUAL ABUSE

- Cause a person with a mental disorder to watch a sexual act by inducement, threat or deception

The purpose of these offences is to criminalise the sexual exploitation of a person with a mental disorder who may have capacity, but is vulnerable to exploitation, e.g. a person vulnerable to exploitation agreeing to engage in sexual activity for a reward such as food or payment.

The final set of offences relating to people with mental disorder are covered by sections 38-41 of the Act and they apply in the context of care workers and mentally disordered people. Under this part of the Act, consent or the absence of consent is immaterial as the perpetrator is considered by law to have known or reasonably been expected to know that the victim had a mental disorder, unless sufficient evidence is presented to question this assumption.

A care worker for purposes of the law is defined as ‘somebody having functions in the course of his or her employment that brings, or is likely to bring, him or her into regular face-to-face contact with the mentally disordered person’.

The offences applying to this area of legislation are:

- engaging in sexual activity with a person with a mental disorder
- causing or inciting sexual activity
- engaging in sexual activity in the presence of a person with a mental disorder
- causing a person with a mental disorder to watch a sexual act

These offences do not apply where:

- the mentally disordered person is 16 years old or more and is lawfully married to the care worker, or
- where a sexual relationship existed between the two people, before the care worker became involved in the care of the mentally disordered person.
Examples of psychological abuse include: emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Psychological abuse can often be insidious and take professionals longer to recognise. Possible indicators that psychological abuse may be occurring include: low self-esteem, deference, passivity, fear, defensiveness or ambivalence, emotional withdrawal or self-harming behaviour.

A number of the legal remedies for domestic abuse also apply when working with psychological abuse, as use of power, coercion and control are consistent features in relationships where domestic abuse is occurring. Antisocial Behaviour Legislation can also be a tool in dealing with psychological abuse – for information and advice consider contacting your local Antisocial Behaviour Team.

Cyber bullying
This term is used to refer to harassment or bullying via; email, instant messaging, chat room exchanges, web site posts, digital message or images sent to a cellular phone or any other media for data exchange. Sometimes it involves people teasing and bullying each other via digital media. It may involve an adult being persecuted over politics, religious or other beliefs. It can go to an extreme where it causes significant psychological harm to the victim and has resulted in self-harm and suicide.

Like traditional bullying, it involves an imbalance of power, use of aggression and often takes on a repetitive pattern. Common presentations include:

- **Harassment** – repeatedly sending offensive, rude and insulting messages
- **Denigration** – posting derogatory information about someone and/or (digitally altered) images
- **Flaming** – fighting online, often using vulgar language
- **Impersonation** – hacking another’s email or social media to post
TYPES OF ABUSE

PSYCHOLOGICAL ABUSE

- embarrassing material

- Outing and Trickery – sharing another’s secrets or tricking someone into revealing embarrassing information

- Cyber Stalking – repeated threats or online activity that makes a person afraid for their safety

If violence is threatened, sexually explicit material is received or used, or when there is stalking or an invasion of an individual’s privacy, then the cyber bully has committed a crime and it should be referred to the Police.

For help, advice or support contact The National Bullying Helpline:
Examples of financial or material abuse include: theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Financial abuse of people with care and support needs is a serious and widespread problem. It can be perpetrated by a wide range of people in positions of trust, including family members, friends, neighbours, informal and paid carers, professionals, solicitors and clergy. In criminal law, financial abuse may constitute a variety of offences, including; theft, burglary, robbery, fraud, false accounting or forgery. For more information on this see Legal Framework on Financial Abuse.

Of increasing concern is the amount of ‘cold calling’ or ‘scamming’ taking place – whereby vulnerable people are (sometimes targeted) tricked or pressurised into parting with (sometimes large) sums of money in return for unsatisfactory, little or no work by bogus tradespersons, or simply tricksters from either the UK or abroad. The increasing use of the is making this problem more widespread. For relevant legislation for cold calling, rogue tradesmen and fraud see here.

The potential impact of financial or material abuse should not be underestimated as it can significantly threaten an adult’s health and wellbeing. Most financial abuse amounts to theft or fraud and should be referred to the Police for a criminal investigation. Professionals should also consider whether the situation requires collaborative working from a wider group of organisations, including for example shops, Trading Standards and financial institutions, such as banks.

Examples of financial crime perpetrated against people with care and support needs may include (but is not limited to):
- benefits or allowances not being received
- an appointee, deputy or attorney not paying agreed contributions towards care costs, or not passing on the weekly personal allowance for unsatisfactory, little or no work by bogus tradespersons, or simply tricksters from either the UK or abroad.
- ‘befriending’ of vulnerable people in order to access their money
- using access to bank accounts of...
TYPES OF ABUSE

FINANCIAL OR MATERIAL ABUSE

debit cards to withdraw additional funds for personal gain
- withdrawals of cash or transfer of property by either registered or unregistered Attorney’s, or using fake “Lasting Power of Attorney” documentation
- unlawfully taking over finances
- provision of goods or services that are unnecessary, of poor standard, or for a higher cost than market value
- mass-marketing fraud i.e. direct mailing around lottery scams or advance fee fraud – encouraging people to send money
- identity theft – stolen identity or impersonation in order to obtain loans or bank accounts. This can occur via a phishing scheme, or through grooming the person for information

Where the allegation of abuse involves concerns about the behaviour of someone who has authority to manage an adult’s money, the relevant body should be informed.

If there are concerns about the behaviour of someone who holds Power of Attorney for Property & Financial Affairs, or is acting as a Court appointed Deputy, the Office of the Public Guardian (OPG) should be notified – they can investigate the actions of a Deputy or Attorney and can also refer concerns to other agencies The OPG can make an application to the Court of Protection if it needs to take action against the attorney or Deputy.

See below for more information about:

- Making, registering or ending a Lasting Power of Attorney
- The role of the OPG and how to report a concern about an attorney of deputy
- The Department of Work & Pensions (DWP)
TYPES OF ABUSE

FINANCIAL OR MATERIAL ABUSE

Legal Framework on Financial Abuse

Theft – a person is guilty of theft if they dishonestly appropriate property belonging to somebody else, with the intention of permanently depriving the other person of it (s.1 Theft Act 1968).

Fraud

The Fraud Act 2006 relates to three main offences:
- fraud by false representation
- fraud by failure to disclose information
- fraud by abuse of position

The last of three is particularly relevant in the context of those with care and support needs and requires three ingredients, namely that the perpetrator:
1. occupies a position in which they are expected to safeguarding, or at least not act against the financial interests of another person
2. dishonestly abuses their position
3. intends through misuse of their position to make personal gain, or gain to another – or to cause loss to another, or expose another to the risk of loss

False Accounting

This offence requires dishonesty, with a view to gain or to cause loss to somebody else (s.17 Theft Act 1968). It constitutes destroying, defacing, concealing or falsifying accounts, records or documents or making use of these knowing they may be misleading, false or deceptive.

Forgery

A person makes or attempts to make a false document, intending to use it in order to persuade someone else that it is genuine and thereby to prejudicially act (s.1 Forgery & Counterfeiting Act 1981).
TYPES OF ABUSE

- Physical abuse
- Domestic abuse
- Domestic abuse – Forced marriage
- Domestic abuse – ‘ Honour based’ abuse
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self-neglect

THE CARE ACT 2014

MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

GAINING ACCESS TO ADULTS AT RISK

SAFEGUARDING ADULTS AND HUMAN RIGHTS

DISCLOSURE AND BARRING

HEALTH AND SOCIAL CARE ACT 2008

THE ROLE OF THE CRIMINAL JUSTICE SYSTEM

MANAGING ALLEGATIONS AGAINST STAFF AND VOLUNTEERS WORKING WITH ADULTS

FINANCIAL OR MATERIAL ABUSE

Legislation for cold calling, rogue tradesmen and fraud

- Pedlars Act 1871
- Trade Descriptions Act 1968
- Enterprise Act 2002
- The Consumer Protection from Unfair Trading Regulations 2008
- Cancellation of Contracts Made in Consumer’s Home or Place of Work Regulations Act 2008

Case study Financial abuse

Case study
0800 137 915

SAFEGUARDING UNDER THE CARE ACT (2014)
This definition encompasses: slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude or inhumane treatment.

Slavery is not an issue confined to history or an issue that only exists in certain countries – it is something that is still happening today. It is a global problem and the UK is no exception. In the UK in 2013, according to the UK National Referral Mechanism Statistics there was a 47% increase in the number of cases reported on the previous year. These statistics only relate to reported cases. Slavery's hidden nature means actual numbers are likely to be significantly higher.

Types of slavery include:
- Child trafficking
- Forced labour / debt bondage
- Sexual exploitation
- Criminal exploitation
- Domestic servitude

Victims can be men, women and children, of all ages. It is normally more prevalent amongst the most vulnerable, minority or socially excluded groups. Signs of slavery are often hidden, but there are some common signs to be aware of:
- Physical appearance – victims may look malnourished or unkempt or seem withdrawn
- Isolation – victims are often not permitted to travel alone and may appear under the control or influence of others
- Poor living conditions – victims may be living in dirty, cramped or crowded accommodation
- Limited or no personal effects – may have no documents and wear the same clothes for days on end, regardless of suitability
TYPES OF ABUSE

MODERN SLAVERY

- Reluctant to seek help – victims may be fearful of agencies both in terms of risk of deportation and or violence to them/their families

If you suspect slavery and you think a person is in immediate danger you should CALL 999.

If you suspect slavery is happening but there is no immediate threat to life you can report it by calling the Modern Day Slavery Hotline on 0800 0121 700 or:

You can fill out the online form here

Legal Framework on Slavery
The Coroners Act 2009, section 71 contains two offences concerning:

- the perpetrator holding a person in slavery or servitude
- the perpetrator requiring a person to perform forced or compulsory labour

For either offence to apply, the perpetrator must either have known, or ought to have known, what was going on.

References to slavery, servitude, forced or compulsory labour are interpreted in accordance with article 4 of the European Convention on Human Rights, which prohibits these.
Examples of discriminatory abuse include: forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

The principles of discrimination are embedded in legislation, including:

- **Human Rights Act 1998**
- **Equality Act 2010**
- **Mental Capacity Act 2005**

Discriminatory Abuse occurs when values, beliefs or culture result in misuse of power that denies opportunity to group or individuals. It can include discrimination on the basis of age, disability, gender (reassignment), marriage, civil partnership, pregnancy, race, religion or belief or sexual orientation and can constitute hate crime incidents.

Hate crime can be reported online here

Call 999 if: the offender is still present, you or anyone else is seriously injured or in danger, or you think the offender may return.
The Care Act statutory guidance defines organisational abuse as: “the mistreatment or abuse or neglect of an adult at risk by a regime or individual’s within settings and services that adults at risk live in or use, that violate the person’s dignity, resulting in lack of respect for their human rights”.

Organisational abuse occurs when the routines, systems and regimes of an institution 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. Organisational abuse can occur in any setting providing health and social care.

The Hull University Abuse in Care Project 2012 identified over 90 indicators or warning signs for concern. In summary these indicators relate to:

- Management and leadership
- Staff skills, knowledge and practice
- Residents’ behaviours and wellbeing
- The service resisting the involvement of external people and isolating individuals
- The way services are planned and delivered
- The quality of basic care and the environment

How concerns are addressed depends on level of risk and the impact on people using the service. There are no set rules and each case should be considered on merit. Concerns around organisational abuse will be dealt with under Buckinghamshire County Council, Adult Social Cares procedures for dealing with provider concerns.

See legal framework on neglect and acts of omission for examples of criminal offences that can be linked to situations where organisational abuse is occurring and it results in ill-treatment or wilful neglect in the context of a provider offence.
Examples of neglect and acts of omission include: ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support, or educational services, the withholding of the necessities of life such as medication, adequate nutrition and heating.

Neglect can take several forms and can be the result of either intentional or unintentional act(s) of omission.

Under s.44 of the Mental Capacity Act 2005 wilful neglect and ill-treatment of a person lacking capacity is a criminal offence. It can result in a fine or imprisonment. The offence can be committed by anyone responsible for the care of the person concerned, i.e. paid staff, family carers and those with legal authority to act on their behalf, e.g. attorney or deputy.

Ill treatment covers both deliberate acts and also those acts, which are reckless and result in ill treatment.

Legal Framework on neglect and acts of omission

Mental Capacity Act 2005

s.44 makes the wilful neglect or ill-treatment of a person lacking capacity a criminal offence. It can result in a fine or imprisonment. The offence can be committed by anyone responsible for the care of the person concerned, i.e. paid staff, family carers and those with legal authority to act on their behalf, e.g. attorney or deputy.
c. And in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.

See s.22-25 of the Act at http://www.legislation.gov.uk/ukpga/2015/2/part/1/crossheading/offences-involving-illtreatment-or-wilful-neglect to understand the penalties that can be applied upon successful conviction for a care provider offence.
The Care Act 2014 has introduced a broader concept of ‘adults in need of care and support’ and is explicit that self-neglect falls within the remit of Adult Safeguarding policies and procedures, if the person concerned has care and support needs.

Statutory guidance states ‘self-neglect covers a wide range of behaviour - neglecting to care for one's personal hygiene, health or surroundings’ (DoH 2014, p234). Guidance is also clear however, that self-neglect may not prompt a section 42 enquiry and an assessment has to be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult’s ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.

BSAB recommends agencies consider the following aspects in relation to self-neglect:

- A lack of care for self to an extent it threatens personal health & safety
- Neglecting to care for personal hygiene, health or surroundings
- An inability to avoid harm to self
- A failure to seek help or access services to meet health or social care needs
- An inability or unwillingness to manage personal affairs

BSAB requires agencies to think of these issues in a broad context– not just in terms of obvious manifestations such as hoarding. Other areas to consider would include; substance misuse issues, individuals with diagnosis...
Compulsive Hoarding is a Mental Disorder marked by an obsessive need to acquire and keep things.

Agencies find working with hoarding particularly problematic; it requires long-term intervention (which will often be recurring), is costly in relation to time, enforcement and support, and professionals often have limited measures available in relation to enforcement.

Many people who hoard don’t see it as a problem or have limited insight into the impact it’s having on their life or on the people around them. Some people do realise it’s a problem, but feel embarrassed or guilty about it and so are reluctant to seek or accept help.

Successful intervention requires a multi-agency response.

According to NHS Choices ‘A hoarding
TYPES OF ABUSE

SELF-NEGLECT – HOARDING

A hoarding disorder is where someone acquires an excessive number of items and stores them in a chaotic manner. The items can be of little or no monetary value and usually result in unmanageable amounts of clutter.

BSAB holds the view that this definition can be applied to both ‘hoarders’ and ‘collectors’. The difference between the two is defined by how the items are organised.

A hoard is disorganised, takes up a lot of space and the items are largely inaccessible. A collection might be well organised and items might be easily accessible. Conversely though, even a ‘collection’ may be so large that items are not easily accessible, take up a lot of space and the amount of ‘clutter’ interferes with everyday life and impacts either on the individual or those around them.

Sometimes a person with a hoarding disorder will hoard a variety of items, while others may only hoard particular objects.

Items that are commonly hoarded include: newspapers & magazines, books, clothes, leaflets, letters (junk mail), bills & receipts, containers, plastic bags, cardboard boxes and household supplies. Some people hoard animals, which they may not be able to look after. More recently, hoarding of data has also become common, e.g. huge numbers of emails, which they’re reluctant to delete.

A hoarding disorder becomes a significant problem when:

- The amount of clutter interferes with everyday life – e.g. the kitchen, bathroom or bedroom cannot be accessed.
- The clutter is causing significant distress or negatively affecting quality of life either to the individual or those around them.

People hoard or collect for different reasons. They may have an emotional attachment to the items (sentimental value), they may think the things they hoard or collect could be useful in the future (utility value), or they may consider the items to be attractive in some way (visual value).

People start to hoard or collect for different reasons – living in poverty for a period of time (e.g. as a child, in wartime), grief, loss of a partner or child, the breakdown of a relationship, redundancy or another serious life event.

Many people with a hoarding disorder may be well presented to the outside world and may cope with other aspects of their life quite well, with no indication of what goes on behind closed doors.
However, it can be a symptom of another, underlying condition, e.g.

- An individual with mobility problems who can’t physically clear the items they have acquired.
- A person with Learning Disabilities or in the early stages of Dementia may be unable to categorise and dispose of items.
- There may be underlying Mental Health conditions, such as depression, Post-Traumatic Stress Disorder (PTSD), psychotic illness or Obsessive Compulsive Disorder (OCD).

Hoarding may be a condition in itself. People who hoard are more likely to:

- be unmarried, be isolated or very private individuals, often living alone
- show signs of self-neglect and/or ‘eccentric’ behaviour
- have had a deprived childhood (lack of material possessions or poor relationships within the family)
- have a family history of hoarding or have grown up in a cluttered home and never learned to prioritise and sort items

A person with a hoarding disorder, in addition to hoarding will often show the following characteristics:

- Find it hard to categorise or organize items
- Have difficulties making decisions
- Struggle to manage everyday tasks, e.g. cooking, cleaning, managing finances
- Become extremely attached to possessions, being unwilling to let anyone touch or borrow them
- Have poor relationships with family or friends

Estimates say that between 2-5% of adults in the UK may have symptoms of a hoarding disorder. It can start as early as the teenage years but most commonly problematic hoarding starts in older age, where it is sometimes diagnosed as Diogenes Syndrome.

People with a hoarding disorder can be identified in various ways:

**Access issues / (un)scheduled visits**

- Difficulties gaining access as this is not welcomed, repairs not requested, debt issues leading to reactive visit, utility checks by contractors who subsequently raise concerns, occupancy checks, GP / Fire / Ambulance attendance in crisis, Social Care visits.
Neighbour, Friends & Family

- Smell, pest problem, complaint from neighbours, overgrown garden, overspill into neighbouring property, information from landlord.

When the person who is hoarding is engaging with an individual or an agency, this should be seen as a breakthrough, as gaining the trust of the individual is key to linking them in with other organisations and people who hoard are frequently mistrustful of new services intervening. Each case of hoarding is unique and will have to be dealt with in a bespoke way. Often the agency that has first contact will be the one to lead on coordinating the response and supporting the individual, but in high risk cases it may be appropriate to consider referral to RAMP.

Hoarding disorders are not easy to treat even when the person is proactively seeking help, but difficulties can be overcome.

The primary treatment is via Cognitive Behavioural Therapy (CBT) – wherein a therapist helps the individual to understand what is making it difficult to throw things away and the reason why clutter has built up.

CBT will need to be combined with practical tasks. Where the individual is willing, it may be possible to support them to plan and manage their own clearance, or for them to engage with an organization that can assist them. Whilst involving them in the process can be slow and time consuming, it is likely to be more successful in the long term.

In some cases it may be necessary to take enforcement action to gain access to the property, to examine and/or execute necessary work or even to gain possession of the property. Enforcement action should only be taken when other action has been attempted but refused or failed or when the case poses serious and immediate risk that requires resolution via legal intervention.

Sustainability is key when finding
TYPES OF ABUSE

SELF-NEGLECT – HOARDING

solutions to hoarding behaviour. It will often return if the underlying cause is not dealt with. It is important to consider what after-care is required. There are a range of options available, including:

- Support package – domiciliary or healthcare package
- Counselling / CBT
- Support to move property or adapt the property
- Fire Safety visit
- Power of Attorney or advocacy provision

BSAB has produced a useful guidance document for practitioners on hoarding, which can be found here.

SELF-NEGLECT – DIOGENES SYNDROME

Diogenes was a Greek philosopher; living in the fourth century B.C., who became famous for living in a barrel. Whether this was true or not, he was also renowned for holding a strong disdain for an ordered house. He believed happiness could only be achieved through contemplation of self, and as such, there was no need to involve others.

Diogenes syndrome, “otherwise known as senile self-neglect syndrome, is used to describe an older adult living in squalor but with no sign of mental or cognitive impairment sufficient to explain the self-neglect” (British Medical Journal 2008;337:a2534).

Whilst in some cases the self-neglect is said to be a sign of obsessive-compulsive disorder, dementia or other mental disorder, many professionals working in the field of older age psychiatry will have come across many cases with no explanatory psychiatric disorder. Indeed, up to half of all people with Diogenes syndrome appear to be reasonably fit.

Diogenes syndrome presents as a breakdown in standards of personal and environmental hygiene. It is intensified by Syllogomania (hoarding of rubbish) and coexists with social withdrawal and an apathetic, shameless attitude to the resulting squalor.

The syndrome is given various explanations:

Macmillan & Shaw (1966) said Diogenes syndrome was consequent upon a refusal to accept help, rather than any ignorance or inactivity on the part of services. They highlighted the affected individual was often resistant to medical intervention. Whilst around half of their study sample had a psychiatric illness, the great majority had a physical disability. Nearly all lived alone; on rare
TYPES OF ABUSE

SELF-NEGLECT – DIOGENES SYNDROME

occasions both partners in a marriage exhibited the syndrome.

Clark et al (1975) first established the diagnosis in relation to elderly people who presented with a 'filthy' personal appearance, a dirty or insanitary home environment and/or hoarding of rubbish, who refused interventions from others. They identified the acutely ill tended to be of high intelligence, were malnourished, had a 'difficult' personality and suffered high mortality. They suggested it was 'a reaction to stress in elderly people with certain personality characteristics'.

Historically, it was often thought that Diogenes syndrome was a personality problem. However, other studies have suggested that the syndrome may in fact be a result of subtle damage to the frontal lobe of the brain – responsible for much of the human ability to plan and look after self. This has been supported by many individuals being observed to have abnormal possessives of objects, which are hoarded in a disordered manner – symptomatic of issues with prefrontal functioning. In other cases though, hoarding is seen to be arranged methodically, which is indicative of a cause other than damage to the brain.

Diogenes Syndrome does not only affect those who are poor or who have had traumatic childhoods. Whilst most patients have a history of one or the other, some individuals who have been studied come from solid family backgrounds, with successful professional lives and more than 50% were of higher intelligence levels.

People with Diogenes Syndrome share common personality traits including; aggressiveness, stubbornness, suspicion of others, unpredictable mood swings, emotional instability and deformed perception of reality.
Types of Abuse

Hoarding - Guidance for Practitioners

Context

Hoarding is marked by an obsessive need to acquire and keep things. People start to hoard or collect for different reasons. They individual may have lived in poverty for a period of time (e.g. as a child in wartime), they may have experienced grief or loss; of a partner or child, the breakdown of a relationship, or loss of employment. They may have experienced another serious life event, which triggered their behaviour.

There may be a family history of hoarding or the individual may have grown up in a cluttered home and never learned to prioritise and sort items.

Compulsive hoarding may have started as a learnt behaviour – buying or collecting things may have helped relieve anxiety or fear they were feeling.

Hoarding may, in effect, have become a comfort blanket. Attempts to reduce the hoard may therefore induce feelings of anxiety or panic.

The behaviour may be a symptom of another, underlying condition, e.g. an individual with mobility problems who can’t physically clear the items they have acquired, a person with learning disabilities or in the early stages of dementia may be unable to categorise and dispose of items, or there may be underlying mental health conditions present, such as depression, Post-Traumatic Stress Disorder (PTSD), psychotic illness or Obsessive Compulsive Disorder (OCD).

Whatever the reason for hoarding, the individual will often have an excessive emotional attachment to their possessions. This may be in terms

- Sentimental value – associated with important memories
- Utility value – belief the items could be useful in the future
- Visual value – consider the items to be attractive in some way

Many people who hoard don’t see it as a problem or have limited insight into the impact it’s having on their life or on the people around them. Some people do realize it’s a problem, but feel embarrassed or guilty about it and so are reluctant to seek or accept help.

An individual with a hoarding disorder may be well presented to the outside world and they may cope with other aspects of their life fairly well, with no indication of what is occurring behind closed doors.
TYPES OF ABUSE

HOARDING - GUIDANCE FOR PRACTITIONERS

There are three primary types of hoarding:

1. **Inanimate objects**
   - Food and containers, clothes or shoes, bags, jewellery, toys, videos, DVDs or CDs, newspapers, magazines and books, medical equipment

2. **Animals**
   - Often with an inability to provide minimal standards of care. The behavior is driven by a desire to ‘save’ the animals and the individual is unable to comprehend any risk to the animals

3. **Data**
   - A relatively new phenomenon, which may present with the storage not only of data itself, but with the hoarding of data collection equipment such as computers, electronic storage devices or paper, bills, receipts or letters

Individuals who hoard often share common characteristics. They are more likely to be unmarried, or be isolated and very private people, often living alone. They will typically alienate family and friends and may be embarrassed to have visitors both professional and personal. They may show signs of self-neglect and/or ‘eccentric behaviour’. They may have poor relationships with others, often finding fault with them; requiring others to function at a high level whilst struggling to organise their self.

An individual with a hoarding disorder may also struggle to manage everyday tasks. They may struggle with the decision to discard items that are no longer needed, including rubbish. At its extreme, their hoarding behaviour may prevent some or all of the rooms in a property being used for their intended purpose. In some cases, the individual may simply move items from one part of the property to another, without ever discarding anything. The individual may appear unkempt and dishevelled due to a lack of, or inability to access, toilet or washing facilities in their home. Some individuals though will use public facilities and maintain personal hygiene and their appearance to the outside world, despite an extremely cluttered home environment.

**Risk**

Hoarding poses significant risk to people living within the property and can also pose a risk to people living nearby. Those living in the property should...
TYPES OF ABUSE

always be advised of the increased fire risk and be encouraged to identify a safe exit route. Referral for professional fire safety and fire prevention advice must be made as a priority and information shared with them allowing crews to respond appropriately in an emergency. Fire Services can provide support and guidance as well as fire safety equipment and be part of a multiagency response.

Evidence of animal hoarding at any level should be reported to the RSPCA.

Response

Hoarding is a complex condition and requires a multiagency response.

Any professional working with an individual who may have or appear to have a hoarding condition should ensure they complete the Comprehensive Assessment and use the Hoarding Guidance and Clutter Index to inform decision making.

When talking to an individual that hoards, practitioners should be mindful of the language they use. They will not be receptive to negative or judgmental comments and use of such language will present as an additional barrier to engagement.

It is also important for practitioners to be mindful of the emotional attachment the individual is likely to feel towards their hoarded items. Language used should not make negative reference to the items, e.g. “rubbish” or “junk” as again, this will create a barrier to engagement.

Practitioners should be respectful and try to reflect the language used by the individual when referring to their possessions, e.g. “my belongings”, “my things”.

The initial focus of any intervention should be on safety and how to organise the possessions to minimise risk – work around discarding can come later when a relationship has been formed and the immediate safety needs have been addressed.
TYPES OF ABUSE

HOARDING - GUIDANCE FOR PRACTITIONERS

In doing this, practitioners should be mindful of the language they use and be mindful of motivational words focused on problem solving rather than using words that are likely to trigger defensiveness. Be conscious of highlighting strengths and positive features or behaviours as this will help to build a good relationship which is the foundation of all work with self-neglect.

SELF-NEGLECT – MORBID OBESITY

Morbid Obesity

Some studies have observed that, a typical constellation of symptoms associated with complex trauma, are more commonly observed among bariatric patients.

Van Hout, Van Oudheusden and Van Heck (2004) identified common presentations amongst morbidly obese patients (particularly those seeking surgical treatment) that were similar to those whom were being treated for complex trauma. These included being depressed, anxious, displaying poor impulse control, low self-esteem and impaired quality of life.

Felitti (2002) identified that obesity could be an adaptive function to early exposure of trauma; ‘obesity was not their problem; it was their protective solution to problems that previously had never been discussed with anyone’.

Research suggests that eating disorder can be a form of self-injury to the body; the body becomes ‘the enemy’ due to distorted survival mechanisms:

- it deserves punishment for being ‘bad’
- or, is made unacceptable in order to protect self
Self-neglect – Assessment of self-neglect

BSAB promotes the use of a ‘Social Psychological Model’ to assess and intervene in cases of self-neglect. This model recognizes the interplay of a variety of physical, mental, social, personal and environmental factors – both internal and external. This model highlights a variety of important factors for consideration:

- Underlying mental disorder, trauma response and/or neuropsychological impairment
- Diminishing social networks and/or economic resource
- Physical and nutritional deterioration
- Personal philosophy and identity

To this end, BSAB has designed a Self-neglect Threshold Tool for use by all agencies when a situation is likely to require a multiagency response, and a Comprehensive Assessment for use by all Professionals when assessing and considering interventions in cases of self-neglect. These documents are part of the Self-neglect Toolkit and can be used by any Professional to consider and scale risk and to identify the level of intervention required.

Self-neglect is a challenging area of practice for Professionals. It is vital to achieve a balance between respect for autonomy and fulfilling the Duty to protect health and wellbeing. Both perspectives are supported by Human Rights arguments.

Assessing someone who is self-neglecting may prove difficult if the individual is unwilling to engage. Research has proven that using short-term, coercive interventions is not effective when working with people whom self-neglect.

Research shows that comprehensive, multidisciplinary responses are needed from as early as possible to deal with the complexities of self-neglect and to prevent entrenched patterns. It is important to think about which Professional within a support network is best placed to successfully engage with the individual concerned in order to maximise the possibility of achieving the best outcome. Literature indicates social care, health, cleaning services, environmental health, Police, Fire
When working with adults whom self-neglect, the starting point is always to establish whether the individual concerned has the Mental Capacity to make decisions about their own wellbeing, and whether or not they are able and/or willing to care for themselves. It is vital to be precise about the decision being assessed and therefore the specific questions that need to be asked. An adult who is capacitated may make decisions that others think of as self-neglect. The Mental Capacity Act 2005 is clear that the Law allows capacitated people to make 'unwise decisions', however, this does not preclude them from the offer of support and intervention. The Care Act 2014 is clear that an adult safeguarding response should be guided by the adult themselves, in order to achieve the outcomes they want to achieve.

Self-neglect is a complex issue, and it is important for practitioners to utilise a wide, legal framework when working with adults who self-neglect.
It is essential to recognise that capacity is dynamic and can fluctuate or change over time. It is therefore vital that a new assessment is undertaken and capacity considered again every time a new concern is raised.

The Mental Capacity Act and Code of Practice relate to decisional capacity. However, research and literature highlight the importance of considering both decisional and executive functioning when working with self-neglect.

It is only if someone is lacking decisional capacity in accordance with the MCA that best interest's decisions can be lawfully made.

Lack of executive functioning cannot be used to say someone lacks capacity under the law and Best Interest Decisions in line with the MCA cannot be made on the strength of it.

However, understanding executive functioning is important when working with self-neglect. It refers to the interplay between making a decision and being capable of acting upon it; weighing up the information and being able to understand the consequences of decisions and actions, but also having the ability to implement those actions.

Research therefore recommends 'articulate and demonstrate' models of assessment. For example, someone may be able to tell you they would call for an ambulance in an emergency, but they may not be capable of doing it.

If someone is deemed to be able to make a specific decision (therefore capacitated under the MCA) but not able to execute the decision, the expectation is that professionals should be offering advice and support appropriate to the level of need. Inaction or failure to acknowledge the lack of executive functioning could prove detrimental to the individual concerned. Where decisional capacity exists in accordance with the MCA, but executive functioning is lacking, it is expected that professionals would follow appropriate care pathways. The challenged may be in getting the person's consent for this.

If an adult who is capacitated (in accordance with the MCA) does not want any intervention or safeguarding action to be taken, it may be appropriate not to intervene any further at that point. In making this decision, it is essential to consider whether:

- anyone else is at risk
- their 'vital interests' are compromised or not - that is, establish that there is no immediate risk of death or major harm
TYPES OF ABUSE

SELF-NEGLIGENCE – MENTAL CAPACITY AND SELF NEGLECT

- all decisions have been fully explained and recorded
- other agencies have been informed and involved as necessary
- there is a route back to re-referral or accessing support should the person change their mind

SUPPORTING PRACTITIONERS WORKING WITH SELF-NEGLECT

Research has shown working with self-neglect is often experienced as lonely, helpless, risky and frustrating and practitioners often refer to feeling exposed. The work can often be difficult and distressing. It is important that practitioners are supported by both systems and agencies to take the ‘slow-burn’ approach, which is required to achieve effective outcomes in this complex area of work. Places and spaces to discuss high-risk cases are required and agencies should promote and facilitate engagement with RAMP.

LEGAL FRAMEWORK AND SELF-NEGLECT

When working with the complexity of self-neglect, it is important for practitioners to utilise a wide, legal framework. Where risk requires the use of coercive Powers, these may not exist under the Care Act, but may exist within other legislation and may be used.

However, saying this, practitioners ultimately must also be mindful of the Human Rights Act 1998 in terms of ‘protection of the individual from the State’; the right to respect for private and family life – interference must be justified as lawful and proportionate (Article 8, European Convention).

Examples of wider legislation to be mindful of are:

- Care Act 2014
- National Health Service Act 2006
- Mental Capacity Act 2005
TYPES OF ABUSE

LEGAL FRAMEWORK AND SELF-NEGLECT

- Inherent Jurisdiction of the High Court
- Mental Health Act 1983
- Public Health Act 1936, Environmental Protection Act 1990
- Police & Criminal Evidence Act 1984
- Rights of Entry (Gas and Electricity Boards) Act 1986
- Animal Welfare Act 2006
- Prevention of Damage by Pests Act 1949
- Housing Act 2004
- Refuse Disposal (Amenity) Act 1978
- Coroners & Justice Act 2009
- Common Law – Gross negligence manslaughter
- Wilful Neglect (Mental Capacity Act 2006, s44)
- Building Act 1984
- Public Health (Control of Disease) Act 1984
- Crime & Disorder Act 1998

Some in particular to be mindful of and their relevance in self-neglect are outlined below.

Care Act 2014

The general duty of a LA under section 1 of this Act is to promote the individual’s wellbeing. This refers to:

- Personal dignity
- Physical and mental health and emotional wellbeing
- Protection from abuse or neglect
- Control by the individual over day-to-day life
- Participation in work, education, training or recreation
- Social and economic wellbeing
- Domestic, family and personal relationships
- Suitability of living accommodation
- The individual’s contribution to society

In exercising this duty, the LA must have regard to:

- Beginning with the assumption the individual is best placed to judge what constitutes their wellbeing and their own views, wishes and feelings
- Preventing, delaying or reducing needs for care and support
- Ensuring decisions about an individual are made with regard to all circumstances – not only on age, appearance, condition or an aspect of behaviour that might lead to unjustified assumptions about wellbeing
- Enabling them to participate as fully
TYPES OF ABUSE

LEGAL FRAMEWORK AND SELF-NEGLECT

as possible in decision making

- Achieving a balance between their wellbeing and that of carers
- The need to protect individuals from abuse and neglect
- The need to ensure restrictions on rights or liberty are kept to the minimum necessary

Section 6 of the Care Act requires the LA and partners to cooperate to:

- Promote the wellbeing of people with needs for care and support and their carers
- Improve the quality of care and support and outcomes for individuals and carers
- Protect those adults with care and support needs, who are experiencing, or are at risk of abuse or neglect
- Identify lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect and applying those lessons to future practice.

Research has shown that a multiagency approach is essential in working with self-neglect – the Duty to cooperate under section 6 is therefore an important one. Partner agencies must comply with a LA request for cooperation in a specific case unless it considers that to do so would:

- Be incompatible with its own Duties or
- Otherwise have an adverse effect on the exercise of its functions

A refusal must be accompanied by written reasons.

A needs assessment under section 9 must include assessment of the impact on wellbeing, the outcome the individual wishes to achieve in day-to-day life and whether or to what extent the provision of care and support could support those desired outcomes. In addition to care and support, the LA must also consider whether the individual would benefit from preventative services, information / advice or anything else that might be available in the community.

Section 11 of the Care Act states that if the individual concerned refuses assessment, the LA is not required to complete the assessment unless:
TYPES OF ABUSE

LEGAL FRAMEWORK AND SELF-NEGLECT

- The individual lacks capacity to refuse assessment and the LA is satisfied assessment would be in best interests
- The individual is experiencing, or is at risk of, abuse or neglect
- The individual changes their mind about being assessed
- Since previous refusal, needs or circumstances have changed, the Duty to assess remains, but subject to further refusal

In the event of self-neglect, the Duty to assess therefore remains as ‘the individual is experiencing, or is at risk of, abuse or neglect’ – the LA and relevant partner agencies must therefore persist and do their best to engage the individual concerned and ultimately be able to evidence Discharge of Duty of Care. In doing so though, agencies must be mindful of Article 8 of the Human Rights Act; entry to premises requires permission as to do so without this could be trespass and an infringement of Article 8 – unless other legislation offers a coercive Power in this respect. At its extreme, assessment without consent could be considered an assault and in breach of Article 8 rights – unless other legislation offers a coercive Power in this respect.

Practitioners need to show all reasonable steps have been taken to do an assessment and this must be evidenced, including that Duty to Assess has been fully explored, including the consequences of not assessing, e.g. consideration of whether an application should be made to the Courts under Inherent Jurisdiction where risk warrants it.

Mental Capacity Act 2005 / Code of Practice and related guidance

The Mental Capacity Act (MCA) sets out the statutory framework you must use to show whether or not someone might lack capacity to make a decision.

The ‘two-stage test’ should be used to trigger an assessment of capacity where it is considered capacity may be lacking. This test involves asking the following:

- “Is there an impairment of or disturbance in the functioning of a person’s mind or brain”? If so, “Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision”?

There are a number of reasons why professionals may reasonably question whether a person has capacity to make a specific decision. Examples include; the person’s behaviour or circumstances, another person’s concerns, previous
TYPES OF ABUSE

LEGAL FRAMEWORK AND SELF-NEGLECT

diagnosis of an impairment or disturbance that affects how their mind or brain works.

The Act also sets out a ‘Best Interests Checklist’, which you must use when making a decision on behalf of someone who lacks capacity.

The five principles in the Act are:

- Presumption of capacity
- Individuals being supported to make their own decisions
- People have the right to make unwise or eccentric decisions
- Any decision made on behalf of an incapacitated person, must be in their Best Interests
- Any intervention should be the less restrictive option and should be proportionate to the particular circumstance of the case

Mental Capacity is fluid and assessment should be dynamic, with a new assessment being undertaken each time a concern is raised. Every time an assessment is undertaken professionals must be very clear about what decision is being made, as this may differ according to context.

Practitioners and service users should see www.assessright.co.uk for a free capacity assessment resource, which may be found to be useful.

Research has evidenced that commonly geriatricians and other practitioners are taking a different view when considering Mental Capacity in the context of self-neglect. Whereas for example, Social Workers are focusing on decisional capacity, geriatricians are also looking at executive capacity, using an articulate and demonstrate approach. See section 21 for your responsibilities in relation to executive capacity, versus what is lawful in the context of the MCA.

Inherent Jurisdiction of the High Court

Decisions not covered by the MCA and where an individual has capacity, or deemed to lack capacity not under the auspices of the MCA 2005.

Mental Health Act 1983

Section 2 – Admission for Assessment

Allows compulsory admission for assessment, or for assessment followed by medical treatment for up to 28 days.

An application under Section 2 can be made by a relative or an Approved Mental Health Professional (AMHP) and must be supported by two medical recommendations, one of which must be from an approved doctor under Sec 12 of the Act, i.e. someone who has
TYPES OF ABUSE

LEGAL FRAMEWORK AND SELF-NEGLECT

special experience in the diagnosis and treatment of mental disorder – this is generally a consultant or senior registrar psychiatrist.

The medical recommendations must agree that the patient:-

a. is suffering from a mental disorder of a nature or degree which warrants their detention and

b. ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons

c. appropriate medical treatment is available for them

Section 7 – Guardianship

A Guardianship application may be made in respect of a patient on the grounds that:-

a. they are suffering from mental disorder which warrants their reception into guardianship and

b. it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received

The purpose of Guardianship is to enable ‘the establishment of an authoritative framework for working with a patient with a minimum of constraint to achieve as independent a life as possible within the community and must be part of the patients overall care and treatment plan’.

Public Health Act 1936

This contains the principal powers to deal with filthy and verminous premises.

Section 83 states that where a Local Authority, upon consideration of a report from any of their officers, or other information in their possession, is satisfied that any premises:-

a. are in such a filthy or unwholesome condition as to be prejudicial to health or

b. are verminous

the Local Authority shall give notice to the owner or occupier of the premises
TYPES OF ABUSE

requiring them to take such steps as may be specified in the notice to remedy the condition of the premises.

The steps which are required to be taken must be specified in the notice and may include:

- Cleansing and disinfecting
- Destruction or removal of vermin
- Removal of wallpaper and wall coverings
- Interior of any other premises to be painted, distempered or whitewashed

There is no appeal against a Section 83 notice and the Local Authority has the power to carry out the works in default and recover the costs.

Public Health Act 1961

Section 36 makes provision for the Local Authority to serve notice requiring the vacation of verminous premises and adjoining premises for the purposes of fumigation to destroy vermin. Temporary accommodation must be provided and there is the right of appeal.

Section 37 provides for household articles to be disinfested or destroyed at the expense of the owner.

Housing Act 2004

Gives the power to the Local Authority to inspect a property to identify any hazards that would be likely to cause harm and to take enforcement action where necessary to reduce the risk of harm. Where a property is deemed to be ‘filthy or verminous’ under the Public Health Act, it is more appropriate to use that legislation in dealing with the issues. Where there are structural concerns, then the Housing Act may be suitable.

Environment Protection Act 1990

Sections 79-80 allow a Local Authority to serve an abatement notice in relation to any premises in such a state as to be prejudicial to health or a nuisance. Evidences show that Judges are reluctant to use this legislation in practice and a high burden of proof is required – it is therefore only generally used in extreme situations.

Building Act 1984

Section 76 enables urgent action to be taken to remedy defects to premises which are in such a state as to be prejudicial to health or a nuisance.
TYPES OF ABUSE

LEGAL FRAMEWORK AND SELF-NEGLECT

Prevention of Damage by Pests Act 1949
The Local Authority has a Duty to take action against the owners/occupiers of land where there is evidence of pests. These are usually rats and mice but may include an infestation of any pest that has a public health significance.

Public Health (Control of Disease) Act 1984
Section 46 imposes a Duty on the Local Authority to bury or cremate the body of any person found dead in their area in any case where it appears that no suitable arrangements for the disposal of the body have been made. Costs may be reclaimed from the estate or any person liable to maintain the deceased.

Animal Welfare Act 2006
This Act brings together and consolidates over 20 pieces of legislation into one Act, and updates legislation that exists to promote the welfare of vertebrate animals (other than those in the wild). Which types of animal are protected under the Act depends on the offence in question, e.g. the Duty to ensure an animal’s welfare only applies to animals that are owned or for which someone is otherwise responsible. Cruelty and fighting offences have wider application. Key elements include:

- Places a ‘duty of care’ on people to ensure the needs of any animal for which they are responsible
- Creates a new offence of failing to provide for the needs of an animal in your care
- Allows action to protect animals to be taken much earlier – intervention can take place before and animal begins to suffer
- Places emphasis on owners to understand their responsibilities and take all reasonable steps to provide for the needs of their animals

Refuse Disposal (Amenity) Act 1978
May afford Powers of Entry to enter upon land, which is in the open air, for the purposes of assessing whether powers to remove and dispose of refuse are to be used.
TYPES OF ABUSE

- Physical abuse
- Domestic abuse
- Domestic abuse – Forced marriage
- Domestic abuse – ‘Honour based’ abuse
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self-neglect

THE CARE ACT 2014

MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

GAINING ACCESS TO ADULTS AT RISK

SAFEGUARDING ADULTS AND HUMAN RIGHTS

DISCLOSURE AND BARRING

HEALTH AND SOCIAL CARE ACT 2008

THE ROLE OF THE CRIMINAL JUSTICE SYSTEM

MANAGING ALLEGATIONS AGAINST STAFF AND VOLUNTEERS WORKING WITH ADULTS

LEGAL FRAMEWORK AND SELF-NEGLECT

Human Rights Act 1998

The Human Rights Act came into full force on 2 October 2000. The aim of the Act is to ensure a set of basic human rights, which are listed in the Act, are fully respected and enforced in the UK. The Act is designed to make public authorities more accountable for their decisions and public authorities must therefore act in accordance with the Convention on Human Rights. The national courts will be able to enforce such rights against these authorities. The most relevant Articles are likely to be:-

- Article 1 – obligation to respect human rights
- Article 2 – right to life
- Article 3 – right not to be subjected to torture or to inhuman or degrading treatment
- Article 5 – right to liberty and security
- Article 8 – right to respect for Private and Family Life

There is also a right under the Convention for the Protection of Property (Article 1, Part II).

The Convention sets out there shall be no interference by a public authority with the exercise of these rights except in accordance with law, necessary in democratic society and for a specified purpose; public safety, crime prevention, protection of health/morals, economic wellbeing of the country, protection of the rights and freedom of others etc.

SIGNIFICANT FACTORS IN SELF NEGLECT

Significant Factors in Self Neglect include:

- Physical health problems
- Untreated medical conditions
- Impaired physical functioning or pain
- Functional impairment
- Nutritional deficiency 9vitamin E, amino acids, oxidative stress)
- Mental Health problems – depression, impaired cognitive functioning, frontal lobe dysfunction
- Personality traits
- Traumatic histories and life changing events
- High perceived self-efficacy scores
- Alcohol and/or substance use and misuse
TYPES OF ABUSE

- Physical abuse
- Domestic abuse
- Domestic abuse – Forced marriage
- Domestic abuse – ‘Honour based’ abuse
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
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TYPES OF ABUSE

SIGNIFICANT FACTORS IN SELF NEGLECT

- Isolation – diminished social networks, lack of access to services
- Poverty

These can overlap and reinforce each other, and there may well be multiple factors involved. Also, there may be either a cause or an effect of self-neglect, or both (Braye et al 2011).

INDICATORS OF SELF-NEGLECT

Possible Indicators of self-neglect may include:

- Being unable or unwilling to provide adequate care for self; very poor personal hygiene, an unkempt appearance (e.g. excessively long toe nails, lack of necessary aids such as glasses, hearing aids or dentures)
- Malnutrition and/or dehydration, little or no fresh food in the fridge or food is mouldy or very out of date
- Malnutrition and/or dehydration, little or no fresh food in the fridge or food is mouldy or very out of date
- Living in squalid or unsanitary conditions for example; rodent infested or living with a toilet completely blocked with faeces
- Neglecting household maintenance and therefore creating hazards or fire risks; rotten floor boards creating trip hazards, lack of a boiler, absence of electrical maintenance, no heat, no running water
- Demonstrating ‘eccentric’ behaviour or lifestyle, such as obsessive hoarding or collecting a large number of animals in inappropriate conditions – see Appendix 1 for more information on ‘Hoarding’
- Untreated or improperly attended medical conditions, non-compliance with necessary health or care services, inability or unwillingness to take medication or treat illness or injury
- Coming into repeated contact with services as a result of seemingly capacitated but high risk decision making and risk taking.
TYPES OF ABUSE

RAMP (RISK ASSESSMENT & MANAGEMENT PANEL)

RAMP is a multiagency panel chaired by Thames Valley Police involving Adult Social Care, Mental Health Services, Buckinghamshire Fire Service and other appropriate agency representatives on a case-by-case basis. RAMP aims to support practitioners and service users in circumstances where engagement and risk management are challenging.

RAMP is aimed at improving the way we work in partnership with adults who are at risk due to a lifestyle, which threatens their health and wellbeing. RAMP offers consistent, tailored and coordinated guidance to support the individual’s needs whilst respecting the rights of others. (RAMP vision statement).

It is important for agencies to understand that RAMP is a multiagency panel aimed at supporting and offering advice and guidance in relation to the management of individual cases. It is not responsible for actual case management. Referrals regarding adults at risk are received by Adult Social Care Safeguarding Team; these will be reviewed before a decision is made to refer to the RAMP. Cases of Self Neglect will only be referred to RAMP where the individual has capacity. The professional referring into the Safeguarding Adults Team remains responsible for informing the subject (or appropriate person) of the referral, unless there are exceptional and clearly documented reasons not to do so. Consent will be sought by the Safeguarding Adults Team prior to the case progressing into RAMP, with this being recorded on their systems and disseminated to partner agencies as appropriate. Consent should always be sought from the individual or their representative unless doing so would:

- Place the individual (or another person) at increased risk of significant harm.
- Prejudice the prevention, detection or prosecution of a serious crime – this is likely to cover most criminal offences relating to children and adults.
- Lead to an unjustified delay in making enquiries about allegations of significant harm to an individual.

There are four possible outcomes arising from this review by the Safeguarding Adults Team:

- Immediate protective measures required – does not proceed to RAMP.
- No immediate concerns for health and welfare, evidence that practitioners have been unable to engage with or improve the adult’s circumstances – consider RAMP.
TYPES OF ABUSE

RAMP (RISK ASSESSMENT & MANAGEMENT PANEL)

- Concerns that do not present immediate protection issues and insufficient evidence of prior intervention to assess and manage the risk – return to the referrer with advice.
- Concerns that have had evidence of prior intervention but these have not been effective in managing the risk – refer to RAMP.

Once a referral is progressed to RAMP, information from other sources will be collected and reviewed. Details can be found in RAMP – Operating Principles.

DIVERSITY AND SELF-NEGLECT

As with any area of practice, it is important to be aware of diversity when working with self-neglect. In broad terms this means valuing the contribution of everyone in society, embracing and valuing difference.

Evidence based practice is essential. Personal values should not be permitted to pass judgement on what is ‘acceptable’ or ‘not acceptable’ and subjective language such as ‘dirty’, ‘filthy’, ‘smelly’ should not be used and should be replaced with factual descriptions and use of scaling tools such as, for example, the Clutter Index, which can be found within the Self-Neglect Assessment Toolkit. Staff should be mindful of body language and other non-verbal communication when working with self-neglect as these can be powerful and create barriers to engagement.

In achieving cultural awareness and cultural sensitivity we must understand other cultures and ethnic groups, using that knowledge to respect difference and provide services in a way that demonstrates that awareness. When working with people from different cultures it is important to understand that human beings are not neutral and they cannot be expected to assimilate with our own default expectations and requirements.

To be culturally conscious it is important for practitioners to understand themselves before they can understand others and to be aware of how their own culture informs themselves and their actions.

When considering culture services must be mindful of context; for example, a Jamaican in Jamaica where they
TYPES OF ABUSE

DIVERSITY AND SELF-NEGLECT

are in the majority, may experience relationships differently as a Jamaican in the UK where they are in a minority.

Services should be mindful of language; the different connotations attached and different responses it evokes.

Attention must be given to avoiding a deficit narrative and moving to reflecting diversity as a contributory asset.

Not all services take the same approach to working with diversity. In order for services to develop cultural competency they must demonstrate both cultural awareness and sensitivity. Cultural competency can be defined as ‘the knowledge and interpersonal skills

that allow providers to understand, appreciate, and work with individuals from cultures other than their own’ (Campbell-Stephens, 2015).

In working with any form of abuse or neglect, including self-neglect all individuals have the right to be protected from harm with due regard to who they are. ‘Culture’ is no excuse for causing or allowing harm. We need to be clear about the difference between culturally specific practice that is not harmful, and incidents of abuse or neglect that may be linked to aspects of cultural belief or practice and which may do, or is causing harm.

PREVENT / RADICALISATION

PREVENT is a key element of the Government’s Counter Terrorism Strategy and is aimed at stopping people from supporting or participating in terrorism. The Counter Terrorism and Security Act 2015 contains a PREVENT duty for statutory agencies. At its heart, is the concept of early intervention to divert people away from being drawn into terrorist activity.

The Counter Terrorism and Security Act 2015

Indicators of someone potentially being at risk of radicalisation can include but are not limited to:

• Family tensions
• Sense of isolation
• Migration
• Personal identify problems or distancing from cultural heritage
• Experience of racism or discrimination
• Feeling of failure
TYPES OF ABUSE

PREVENT / RADICALISATION

- Spending time in the company of suspected terrorists
- Changing style of dress or personal appearance to accord with a group
- Day to day behaviour becoming centred on extremist ideology, group or cause
- Loss of interest in other friends and activities not associated with the extremist ideology, group or cause
- Possession of material or symbols associated with an extremist cause
- Attempts to recruit others to the ideology, group or cause
- Communication with others that suggests identification with an ideology, group or cause

Channel draws on existing collaboration between local authorities, statutory partners, Police and the local community to identify at an early stage and support any individual who may be at risk of becoming involved in violent extremism (domestic and international), or have already been recruited by violent extremists. This is regardless of age, faith, ethnicity or background.

Referrals to Channel are received by the Police via the PREVENT pathway. Concerned parties should contact the PREVENT lead for their organisation; in the absence of a PREVENT lead they should contact the Safeguarding Adults Team on 0800 137 915 or Police on 101.

MULTIAGENCY FRAMEWORKS

- MARAC
- MAPPA
- RAMP (Risk Assessment Management Panel)
- Channel

SELF-NEGLECT TOOLKIT

- Self-neglect Threshold Tool
- Comprehensive Assessment
- Hoarding Guidance
- Clutter Index

LEGALISATION AND GUIDANCE

LEGISLATION AND GUIDANCE

SAFEGUARDING UNDER THE CARE ACT (2014)

– MENTAL CAPACITY AND DEPRIVATION OF LIBERTY
– GAINING ACCESS TO ADULTS AT RISK
– SAFEGUARDING ADULTS AND HUMAN RIGHTS
– DISCLOSURE AND BARRING
– HEALTH AND SOCIAL CARE ACT 2008
– THE ROLE OF THE CRIMINAL JUSTICE SYSTEM
– MANAGING ALLEGATIONS AGAINST STAFF AND VOLUNTEERS WORKING WITH ADULTS

0800 137 915

Self-neglect Threshold Tool

Comprehensive Assessment

Hoarding Guidance

Clutter Index

Channel Duty Guidance
THE CARE ACT 2014

BACKGROUND

The Care Act 2014 received Royal Assent on 14th May 2014. The Act for the first time places Safeguarding on a statutory footing.

Part 1 of the Act, which includes our safeguarding duties (sections 42-46) comes into force on the 1st April 2015.

The Care Act introduces major reforms to the legal framework for adult care and support in England - to the duties of local authorities; to the rights of those in need of care and support; and to the funding system for care and support.

These changes will impact on the way we do business and the roles of our workforce. They will also have an impact on care providers and user organisations and their roles in the delivery of care, and the expectations and duties placed on them by the new legislation.
THE CARE ACT 2014

GUIDANCE

SAFEGUARDING

The Care Act sets out formal duties and requirements for local authorities in relation to safeguarding adults.

The Care Act requires that the local authority ("LA") must:

- Make enquiries, or ensure others do so on our behalf, if it believes that an adult, who is in need of care and attention, is being abused or neglected, or is at risk of, abuse or neglect, and that they are unable to protect themselves. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom;
- Set up a Safeguarding Adults Board (BSAB) - The purpose of the BSAB is to help and protect adults in our area who are suffering, or at risk of suffering, abuse or neglect and to ensure that the local authority and other agencies and organisations meet their duties under the Care Act. BSABs are responsible for arranging Safeguarding Adults Reviews (SARs);
- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a Safeguarding Enquiry or Safeguarding Adult Review (SAR), where the adult has ‘substantial difficulty’ in being involved in the process and they do not have an appropriate person to represent and support them;
- Cooperation between the Local Authority and each of its relevant partners in accordance with S6 Care Act in order to protect adults experiencing, or at risk of, abuse or neglect;
- Take all reasonable steps to protect the moveable property of an adult who is being cared for away from home in a hospital or in accommodation such as a care home under section 18 or 19 Care Act, and who cannot arrange to protect their property themselves, and no other suitable arrangements are being made or are in place, and where it appears to the LA that there is a risk that the moveable property may be lost or damaged.

The Care Act also requires the LA to follow the safeguarding policies and procedures of custodial settings in its
THE CARE ACT 2014

SAFEGUARDING

area and work with prison and approved premises staff to ensure that all people in custodial settings are safeguarded.

The LA is required to take the lead role in adult safeguarding. Therefore, whilst the LA is able to request that other bodies or organisations undertake safeguarding enquiries on the LA’s behalf, the LA has a duty to ensure that those enquiries are satisfactory and any action is acted upon. The LA should therefore challenge any enquiry where it considers the process and/or outcome to be unsatisfactory.
SAFEGUARDING ADULTS POLICIES AND PROCEDURES

In any organisation, there should be safeguarding adult's policies and procedures. Such policies and procedures should assist those working with adults to develop swift and personalised safeguarding responses and how to involve adults in this decision making. This, in turn, should encourage proportionate responses and improve outcomes for the people concerned.

These should reflect this statutory guidance and are for use locally to support the reduction or removal of safeguarding risks as well as to secure any support to protect the adult and, where necessary, to help the adult recover and develop resilience.
THE CARE ACT 2014

LOCAL SAFEGUARDING ADULTS PROCEDURES THAT ALL PARTNER AGENCIES AND ORGANISATIONS MUST HAVE IN PLACE

All agencies and organisations must develop their own local safeguarding adult’s procedures and protocols that reflect the Buckinghamshire Safeguarding Adults Board Multi-agency Policy and Procedures.

Procedures must include:

- A statement of purpose relating to promoting wellbeing, preventing harm and responding effectively if concerns are raised;
- A statement of roles and responsibility, authority and accountability specific enough to ensure that all staff and volunteers understand their role and limitations;
- A statement of the procedures for dealing with allegations of abuse, including those for dealing with emergencies by ensuring immediate safety, the processes for initially assessing abuse and neglect and deciding when intervention is appropriate, and the arrangements for reporting to the police, urgently when necessary;
- A full list of points of referral indicating how to access support and advice at all times, whether in normal working hours or outside them, with a comprehensive list of contact addresses and telephone numbers, including relevant national and local voluntary bodies;
- An indication of how to record allegations of abuse and neglect, any enquiry and all subsequent action;
- A list of sources of expert advice;
- Information regarding the provisions of the law – criminal, civil and statutory – relevant to adult safeguarding, including local or agency specific information about obtaining legal advice and access to appropriate remedies;
- A full description of channels of inter-agency communication and procedures for information sharing and for decision making;
- A list of all services which might offer access to support or redress;
- Details of how professional disagreements are resolved, especially with regard to whether decisions should be made or enquiries undertaken.

Procedures should be updated to incorporate learning from published research, peer reviews, case law and lessons from recent cases and safeguarding adult’s reviews.
THE CARE ACT 2014

CRIMINAL JUSTICE AND COURTS ACT 2015

This legislation has created the criminal offence of ill-treatment or wilful neglect of any adult and applied it specifically to groups within health and social care.

Section 20 to 25 set out the offence and the penalties.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

This is a summary of the Deprivation of Liberty Safeguards (DoLS) and its implications for health and social care professionals. It is not intended to be a replacement for the DoLS Code of Practice (CoP). Professionals must refer to the Mental Capacity Act (MCA) and DoLS CoP for guidance on specific cases and to inform decisions.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

INTRODUCTION

The Mental Capacity Act 2005 (MCA 2005) provides a statutory framework to empower and protect vulnerable adults who are not able to meet their own decisions. One of the ways it does this is by putting Adults at the heart of the decision-making process.

Capacity describes a person’s ability to make a specific decision at a specific time. Capacity may be fluctuating and therefore any assessment of capacity must be regularly updated.

Professionals and other staff working in safeguarding need to understand and comply with the requirements set out in the Mental Capacity Act.

The Mental Health Act 2007 provides...
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

AN ADULT'S LEGAL RIGHT TO MAKE THEIR OWN DECISIONS

The Mental Capacity Act 2005 sets out in law each person's rights regarding making their own decisions and protects their rights regarding this in law.

Where a person is unable to make a specific decision for themselves, the Act sets out a clear process that must be followed before a decision can be made on their behalf.

People must be assumed to have capacity to make their own decisions and be given all practicable help before anyone treats them as not being able to make their own decisions.

Where an adult is found to lack capacity to make a decision, any action taken, or decision made for, or on their behalf, must be made in their best interests.

Professionals and other staff need to understand and always work in-line with the Mental Capacity Act 2005. They should use their professional judgement and balance many competing views.

Employers should provide considerable guidance and support to ensure that professionals and other staff are able to help adults manage risk in ways and put the adult in control of decision making if possible.

Regular face-to-face supervision from skilled managers is essential to enable staff to work confidently and competently in difficult and sensitive situations.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

PRINCIPLES OF THE ACT

The MCA is underpinned by 5 key principles:

- **A presumption of capacity** – An adult has the right to make his or her own decisions and must be assumed to have capacity unless it is proved otherwise.

- **The right for an adult to be supported to make their own decisions** – An adult must not be treated as unable to make a decision merely because (s)he makes an unwise or bad decision.

- **Best interests** – Anything done for, or on behalf of an adult who lacks capacity must be in that adult’s best interests.

- **Least restrictive intervention** – Anything done for or on behalf of an adult who lacks capacity should be the least restrictive option.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

MENTAL CAPACITY AND SAFEGUARDING

The Act deals with the assessment of a person’s capacity and acts by carers of those who lack capacity:

- Assessing lack of capacity: there is a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a ‘decision-specific’ and time specific test;
- Best interests: an act done or decision made for or on behalf of a person who lacks capacity must be in that person’s best interests;
- Acts in connection with care or treatment: Section 5 offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity. This could cover actions that might otherwise result in criminal prosecution or civil liability if someone has to interfere with the person’s body or property in the course of providing care or treatment;
- Restraint: Section 6 sets out limitations on section 5. It defines restraint as the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of the harm. This section does not extend to deprivation of liberty within the meaning of Article 5(1) of the ECHR.

- Lasting powers of attorney (LPAs) - allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future and allows people to empower an attorney to make health and welfare decisions;
- Court appointed deputies - provides for a system of Court Appointed Deputies to replace Receivership. Deputies can take decisions on welfare, healthcare and financial matters as authorised by the new Court of Protection but they are not able to refuse consent to life sustaining treatment.

Deputies are only appointed if the Court cannot make a one-off decision to resolve the issues.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

MENTAL CAPACITY AND SAFEGUARDING

The MCA created a new public body and a new official to support the statutory framework:

- **The Court of Protection** - has jurisdiction relating to the whole Act, with its own procedures and nominated judges;
- **A Public Guardian**, supported by the Office of the Public Guardian (OPG). The Public Guardian and his staff is the registering authority for LPAs and deputies. They supervise deputies appointed by the Court and provide information to help the Court make decisions. They will also work with other agencies, such as the police and Social Services, to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board will be appointed to scrutinise and review the way in which the Public Guardian discharges his functions. The MCA also includes 3 further key provisions to protect vulnerable people:
  - **Independent Mental Capacity Advocate (IMCA)** - An IMCA is someone appointed to support a person who lacks capacity but has no one to speak for them. They have to be involved where decisions are being made about serious medical treatment or a change in the person’s accommodation where it is provided, or arranged, by the NHS or a local authority. The IMCA makes representations about the person’s wishes, feelings, beliefs and values, and brings to the attention of the decision-maker all relevant factors to the case;
  - **Advance decisions to refuse treatment** - there are statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future;
  - **Criminal offence** - The MCA introduced a new criminal offence of ill treatment or wilful neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

Guidance on the MCA is provided by virtue of a statutory Code of Practice Guidance.

Further information can be found on the Public Guardian website.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

DEPRIVATION OF LIBERTY SAFEGUARDS

The MCA Deprivation of Liberty Safeguards (DOLS) provide procedures to authorise the deprivation of liberty of a person in a hospital or a care home who lacks capacity to consent to be there. The MCA principles of supporting a person to make a decision when possible, and acting at all times in the person’s best interests and in the least restrictive manner, will apply to all decision-making in operating the procedures.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

IDENTIFYING DEPRIVATION OF LIBERTY

There is a difference between deprivation of liberty (which is unlawful, unless authorised) and restrictions on an individual's freedom of movement. Restrictions of movement (if in accordance with the principles and guidance of the Mental Capacity Act, 2005) can be lawfully carried out in someone's best interest to prevent harm.

The difference between restriction of movement and deprivation of liberty is based on degree and intensity. If Managers or Practitioners are in doubt as to whether an adult is being deprived of their liberty, they should seek advice from Legal Services.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

TEST FOR DEPRIVATION OF LIBERTY

The Supreme Court in P v Cheshire West and Chester Council; P&Q v Surrey County Council, March 2014 created an ‘acid test’ to establish when an adult is deprived of their liberty. A person will be deprived of their liberty in circumstances where

- They are under continuous supervision and control; and
- They are not free to leave; and
- They lack Capacity to consent to these arrangements; and
- The care arrangements that result in the DoL are being made by the State.

The Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include:

- the person’s compliance or lack of objection; the reason or purpose behind a particular placement; and the extent to which it enables them to live a relatively normal life for someone with their level of disability.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

AUTHORISING A DEPRIVATION OF LIBERTY

Schedule A1 of the MCA sets out a procedure by which the deprivation of an adult’s liberty who lacks capacity may be authorised in a care home or hospital.

In relation to adults in supported living or in domestic settings, only the Court of Protection can make an order authorising a deprivation of liberty.

Individuals may also be deprived of their liberty under the Mental Health Act if the requirements for detention under that Act are met.
Deprivation of liberty can be in a person’s best interest if it is necessary to protect the person from harm, and is proportionate to the risk of harm. To be lawful, it needs to be authorised to ensure that the person has access to the safeguards and is appropriately represented throughout the authorisation.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

ADVANCED DECISIONS AND LIVING WILLS

These are statements expressing an adult’s views on how they would, or would not, like to be treated, if they are unable to make a decision themselves, i.e. because they have lost capacity.
Under ss24-26 Mental Capacity Act 2005, an adult, who has capacity at the time of making the decision, can make an advance decision to refuse treatment in the event that they lose capacity to make that decision at the time. There are certain safeguards in place under the Act that specify when the decision will be valid in certain circumstances. For more information see Mental Capacity Act.

If the advance decision is a valid and applicable decision, then this should be respected and any treatment given to the adult that is covered by the decision, may incur liability under both civil and criminal law.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

ADVANCED STATEMENT

This is a general statement of an adult’s wishes or views. It can reflect personal choices, religious beliefs or any area of their life which they particularly value. They can also be used to inform agencies on who they would like consulted in the event that a decision has to be made that the adult is incapable of making. Unlike an Advanced Decision, an Advanced Statement is not legally binding, but should be taken into consideration in any safeguarding plans.
MENTAL CAPACITY AND DEPRIVATION OF LIBERTY

THE MENTAL HEALTH ACT 2007 PROVIDES:

- **A definition of mental disorder**
  A single definition now applies throughout the Act.

- **Criteria for detention**
  An appropriate treatment test, which applies to all the longer-term powers of detention. As a result, it is not possible for patients to be compulsorily detained, or their detention continued, unless appropriate medical treatment and all other circumstances of the case is available to the patient.

- **Professional roles**
  The group of practitioners who can take on the functions of approved social worker and the responsible medical officer.

- **Nearest relative**
  Patients have the right to make an application to the county court to displace their nearest relative and enables county courts to displace a nearest relative who it thinks is not suitable to act as such.

- **Supervised Community Treatment**
  SCT for patients following a period of detention in hospital.

- **Electro-convulsive therapy**
  Safeguards for patients.

- **Independent Mental Health Advocates**
  A duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates.
GAINING ACCESS TO ADULTS AT RISK

RELATED GUIDANCE

Identify existing powers which enable access to adults who are, or suspected to be, at risk of abuse or neglect and the legal powers to intervene.

Gaining access to an adult suspected to be at risk of neglect or abuse: a guide for social workers and their managers in England, SCIE 2014
INTRODUCTION

Section 1 of the Care Act 2014 states that a local authority, in exercising its functions under Part 1 of the Act in the case of an individual, must promote that individual’s wellbeing and have regard to a number of factors including the need to ensure that any restriction on the individual’s rights or freedom of action is kept to the minimum necessary for achieving the purpose for which the function is being exercised.
SAFEGUARDING ENQUIRIES

The LA's duties in relation to the making of enquiries do not provide an express legal power of entry or right of unimpeded access to the adult who is subject to such an enquiry. Instead, there are a range of existing legal powers which are available to gain access should this be necessary.

The powers which may be relevant to adult safeguarding situations derive from a variety of sources including, but not limited to, the Mental Capacity Act 2005 (MCA), the Mental Health Act 1983 (MHA) and the Police and Criminal Evidence Act 1984 (PACE), along with the inherent jurisdiction of the High Court and common law powers of the police to prevent or deal with a breach of the peace.

Whether it is necessary to seek legal intervention and which powers would be the most appropriate to rely on in order to gain access to an adult to assess any safeguarding risk, or otherwise protect an adult, will always depend on the individual circumstances of the case. Seeking legal advice for individual cases is always recommended if there is any form of uncertainty or doubt.

Where appropriate, it should be considered whether an application to the court is required, or whether to seek police assistance.

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Where appropriate, it should be considered whether an application to the court is required, or whether to seek police assistance.
DIFFICULTIES IN GAINING ACCESS

There will be a wide range of reasons why, and circumstances when, it may be difficult to gain access to an adult who is the subject of an adult safeguarding enquiry. Some examples include:

- Access to the premises is being denied altogether by a third party on the premises, typically a family member, friend or other informal carer;
- Access to the premises can be gained, but it is not possible to speak to the adult alone - because the third party is insisting on being present;
- The adult themselves is insisting that the third party be present and there are concerns that this person may unduly influence the adult, or their responses to any enquiries.

However, the simple fact of access being refused should not automatically lead to consideration of the use of legal powers. Such situations are often complex and highly sensitive and, if they are to be resolved successfully and safely, will need sensitive handling. All attempts to resolve the situation should begin with negotiation, persuasion and the building of trust. Denial of access may not necessarily be a sign of wrong-doing by the third party; it may be an indication of lack of trust of authority, guilt about their inability to care or fear that the adult will be removed from the home. It is vital that until the facts are established the practitioner adopts an open-minded, non-judgemental approach.

If the situation cannot be resolved, then the LA should consider whether the circumstances justify intervention. There should be a discussion with any relevant partners involved, and where appropriate legal services, about the perceived risks, the likelihood of risk or neglect occurring and the potential outcomes of both intervening and not intervening. As in any other situation, any decisions and the reasons for them should be clearly and fully recorded and shared with others as necessary and lawful. Where the adult lacks capacity this will take the form of a Best Interests Meeting in compliance with the MCA 2005.

If the conclusion is that the use of legal powers is necessary and justifiable, the next step is to consider what powers would be most appropriate and proportionate to the situation.
Therefore managers and practitioners involved in safeguarding need to be aware of existing legal powers which can be used if necessary to gain access in these circumstances.

Recourse to the courts and legal powers should be considered carefully and only as a last resort, after consultation with legal services.

Before any action is taken, managers and practitioners should be satisfied that there are grounds to seek access and that the use of such powers are lawful. If they are in any doubt, advice should be sought from Legal Services prior to any action being taken.
GAINING ACCESS TO ADULTS AT RISK

GAINING ACCESS

At some point during the making of enquiries by the local authority, legal powers may be required to gain access to the adult who is known or suspected to be experiencing, or at risk of, abuse or neglect.

The following legal powers may be relevant, depending on the circumstances:

- Where an adult who lacks capacity and is in need of care and treatment: under s5 MCA 2005 if we reasonably believe that it is in the best interests of that adult we can take steps to provide that care and treatment, including removing them to a place of safety;

- Where an adult with mental capacity, at risk of abuse or neglect, is impeded from exercising that capacity freely e.g. through physical or mental coercion, domestic abuse, etc.: the inherent jurisdiction of the High Court enables the Court to make an order (which could relate to gaining access to an adult) or any remedy which the Court considers appropriate (for example, to facilitate the taking of a decision by an adult with mental capacity free from undue influence, duress or coercion) in circumstances not governed by specific legislation;

- Where there is concern about a mentally disordered adult: Section 115 of the MHA provides the power for an approved mental health professional to enter and inspect any premises (other than a hospital) in which an adult with a mental disorder is living, on production of proper authenticated identification, if the professional has reasonable cause to believe that the adult is not receiving proper care;
GAINING ACCESS TO ADULTS AT RISK

GAINING ACCESS

- Where an adult is believed to have a mental disorder, and there is suspected neglect or abuse: Section 135(1) of the MHA, a Magistrates Court has the power, on application from an approved mental health professional, to allow the police to enter premises using force if necessary and if thought fit, to remove an adult to a place of safety if there is reasonable cause to suspect that they are suffering from a mental disorder and (a) have been, or are being, ill-treated, neglected or not kept under proper control, or (b) are living alone and unable to care for themselves;

- Part II of PACE provides powers to the police to enter and arrest a person who is suspected of committing certain criminal offences;

- Common law power of the police to prevent, and deal with, a breach of the peace. The police have a common law power to enter and arrest a person to prevent a breach of the peace;

- Where there is risk to life and limb: Section 17(1) (e) of PACE gives the police the power to enter premises without a warrant in order to save life and limb or prevent serious damage to property.
SAFEGUARDING ADULTS AND HUMAN RIGHTS

The Human Rights Act 1998 incorporates most of the European Convention of Human Rights into UK law enabling claims by individual victims to be brought in UK courts against any public bodies for breach of those convention rights. The Act makes it unlawful for a public body to act (by commission or omission) in a way that is incompatible with their Convention Rights. Examples of convention rights are, right to a private and family life, right to marry, right to a fair trial, right to liberty and security etc.

The Act requires all legislation to be interpreted and given effect as far as possible in compatibility with the Convention Rights.

Action is taken in the County Court or the High Court to sue for compensation (damages).

All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens. These rights include:

- Article 2: ‘the Right to life’;
- Article 3: ‘Freedom from torture’ (including humiliating and degrading treatment);
- Article 8: ‘Right to private and family life’ (one that sustains the individual).

Any adult at risk of abuse or neglect should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse. It follows that all citizens should have access to relevant services for addressing issues of abuse and neglect, including the civil and criminal justice system and victim support services.

Remedies available should also include measures that achieve behaviour change by those who have perpetrated abuse or neglect.

It is important that the legal rights of all those affected in relation to adults safeguarding are considered and balanced alongside those of the adult at risk. This includes the right to natural justice and a fair right of reply.

See: Human Rights Act 1998
The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

It is responsible for:

- Processing requests for criminal records checks;
- Deciding whether it is appropriate for a person to be placed on or removed from a barred list;
- Placing or removing people from the DBS children’s barred list and adults’ barred list for England, Wales and Northern Ireland.

Regulated activity describes the kind of work to which barring applies and is fully set out in the Safeguarding Vulnerable Groups (NI) Order 2007 (as amended by the Protection of Freedoms Act 2012). The DBS was established under the Protection of Freedoms Act 2012 and carries out the functions previously undertaken by the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). Functions of the CRB and ISA have been transferred to the DBS under the Protection of Freedoms Act 2012 and it became operational on the 1 December 2012.

Related Guidance

- DBS Checking Service Guidance
- Disclosure and Barring Service website
HEALTH AND SOCIAL CARE ACT 2008

See the Health and Social Care Act 2008

- Established the Care Quality Commission (CQC) as the new integrated regulator for health and adult social care, with powers to ensure safe and high quality services. It requires CQC to inspect, investigate and intervene where care providers are failing to meet safety and quality requirements, including hygiene standards;

- Dissolved the Commission for Health Care Audit and Inspection, the Commission for Social Care Inspections (CSCI) and the Mental Health Act Commission;

- Reformed professional regulation to give patients and the public more confidence in the care they receive from health professionals, including the creation of a new adjudicator to make independent decisions about whether individual health professionals should remain in practice;

- Strengthened the protection of vulnerable people using residential care by ensuring that any independent sector care home that provides accommodation together with nursing or personal care on behalf of a local authority is subject to the Human Rights Act 1998;

- Extended Direct Payments to include people who lack capacity. It allows a direct payment to be made to a 'suitable person' who can receive and manage the payment on behalf of a person who lacks Capacity.

Also see Department of Health Guidance: Positive and Proactive Care: reducing the need for restrictive interventions: 2014

0800 137 915

Raising a concern form
THE ROLE OF THE CRIMINAL JUSTICE SYSTEM

INTRODUCTION

The criminal justice system in the UK involves a number of separate bodies who work in partnership to safeguard Adults, in relation to the implementation of legal, judicial and policing processes. This includes the Crown Prosecution Service (CPS) and Police.

The Crown Prosecution Service (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, who may be vulnerable witnesses.

Support is available within the judicial system for those at risk to enable them to bring cases to court and to give the best evidence. If an adult has been the victim of abuse which is also a crime, their support needs can be identified by the police, the CPS and/or others who have contact with the Adult.

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.

Special measures are available in both Crown and Magistrates’ Courts. They include the use of screens, trained Intermediaries to help with communication and arrangements for evidence and cross-examination to be given by video.
CRIMINAL OFFENCES AND ADULT SAFEGUARDING

Everyone is entitled to the protection of the law and access to justice. Behaviour which amounts to abuse and neglect, for example physical or sexual assault or rape, psychological abuse or hate crime, wilful neglect, unlawful imprisonment, theft and fraud and certain forms of discrimination also may be a criminal offence.

Although we have the lead role in making enquiries, where criminal activity is suspected, then the early involvement of the police is necessary.

A criminal investigation by the Police will take priority over all other enquiries. In such cases the Police will lead the investigation, with our support. However, we have an on-going duty to promote the well-being of the adult in these circumstances.
THE ROLE OF THE CRIMINAL JUSTICE SYSTEM

SPECIAL MEASURES

Special Measures were introduced through the Youth Justice and Criminal Evidence Act 1999 (YJCEA) and include a range of measures to support witnesses to give their best evidence and to help reduce some of the anxiety when attending court. Consideration of specials measures should occur from the onset of a police investigation.
THE ROLE OF THE CRIMINAL JUSTICE SYSTEM

VULNERABLE AND INTIMIDATED WITNESSES

Special Measures are available for vulnerable, or intimidated adult witnesses as defined in s16 and 17 of the YJCEA. See also sections 14.70-14.76 of the Care and Support Statutory Guidance. Where it is considered that an Adult meets the requirements for Special Measures, this should be discussed with the Police at the earliest opportunity, and so appropriate action can be taken.
THE ROLE OF THE CRIMINAL JUSTICE SYSTEM

CASES INVOLVING THE CORONER

There is a legal duty to inform the Coroner of any death that has occurred whilst a person is subject to the Deprivation of Liberty Safeguards. The responsibility to notify is shared between the supervisory body and the managing authority.

Note that a person may also be subject to a deprivation of liberty whilst in a domestic setting, such as supported living arrangements, where the State is responsible for imposing such arrangements. Whilst such situations do not come within the remit of the Deprivation of Liberty Safeguards (they must instead be authorised by the Court of Protection), the same procedure should be followed for informing the Coroner.
THE ROLE OF THE CRIMINAL JUSTICE SYSTEM

POLICE AND CROWN PROSECUTION SERVICE (CPS) RESPONSIBILITIES WITH OTHER ORGANISATIONS

- The Police and Crown Prosecution Service (CPS) should agree procedures with the local authority, care providers, housing providers, and the NHS/CCG to cover the following situations:

  - Action pending the outcome of the police and the employer's investigations;
  - Action following a decision to prosecute an individual;
  - Action following a decision not to prosecute;
  - Action pending trial;
  - Responses to both acquittal and conviction.
THE ROLE OF THE CRIMINAL JUSTICE SYSTEM

ILL TREATMENT AND WILFUL NEGLECT

The Mental Capacity Act 2005 created the criminal offences of ill-treatment and wilful neglect in respect of people who lack the ability to make decisions.

The offences can be committed by anyone responsible for that adult’s care and support. This includes:

- Paid staff;
- Family carers;
- People who have the legal authority to act on that adult’s behalf (i.e. persons with power of attorney or court-appointed deputies).

These offences are punishable by fines or imprisonment.

Ill treatment covers both deliberate acts of ill treatment and acts which are reckless which results in ill treatment.

Wilful neglect requires a serious departure from the required standards of treatment and usually means that a person has deliberately failed to carry out an act that they knew they were under a duty to perform.
THE ROLE OF THE CRIMINAL JUSTICE SYSTEM

ABUSE BY AN ATTORNEY OR DEPUTY

If someone has concerns about the actions of an attorney acting under a registered Enduring Power of Attorney (EPA) or Lasting Power of Attorney (LPA), or a deputy appointed by the Court of Protection, they should contact the Office of the Public Guardian (OPG).

The OPG can investigate the actions of a deputy or attorney and can also refer concerns to other relevant agencies. When it makes a referral, the OPG will make sure that the relevant agency keeps it informed of any action taken. The OPG can also make an application to the Court of Protection if it needs to take possible action against the deputy or attorney.

Whilst the OPG primarily investigates financial abuse, it is important to note that it also has a duty to investigate concerns about the actions of an attorney acting under a health and welfare Lasting Power of Attorney or a personal welfare deputy.

The OPG can investigate concerns about an attorney acting under a registered Enduring or Lasting Power of Attorney, regardless of the adult’s capacity to make decisions.

Further information about the role and powers of the OPG and its policy in relation to safeguarding adults can be found online.
MANAGING ALLEGATIONS AGAINST STAFF AND VOLUNTEERS WORKING WITH ADULTS

All organisations working with vulnerable adults should be proactive in reducing the risk of adult abuse and neglect taking place within the services they provide by:

- Developing a person centred safeguarding ethos
- Adopting safe recruitment & effective safe termination of employment practices
- Ensuring all staff understand safe practice, and receive appropriate training in adult safeguarding
- Ensuring all vulnerabilities expressed by staff are taken seriously and responded to at the earliest stage
- Ensuring that the adult and or their representative/advocate is involved in the safeguarding process, that their views and wishes are sought and that employers and staff work in accordance with the principles underpinning making safeguarding personal and that actions are taken proportionately to reduce risk of repetition

The BSAB Procedures listed below should be applied when there is a concern or allegation that any person who works with adults, in connection with his/her employment or voluntary activity, has:

- Behaved in a way that has harmed an adult, or may have harmed an adult
- Possibly committed a criminal offence against, or related to, an adult
- Behaved towards an adult or adults in a way that indicates s/he is unsuitable to work with adults

These behaviours should be considered within the context of the categories of abuse as detailed in the Care and Support Statutory Guidance 2016. These procedures also include concerns relating to inappropriate relationships between members of staff and adults e.g.:

- Having a sexual relationship with an adult if in a position of trust in respect of that adult, even if consensual
- ‘Grooming’, i.e. meeting an adult with intent to commit a relevant offence
- Other ‘grooming’ behaviour giving rise to concerns of a broader adult abuse e.g. inappropriate text / email messages or images, gifts, socialising
- Possession of indecent photographs / pseudo-photographs of the adult or other adults who have care and support needs/ in positions of trust
MANAGING ALLEGATIONS AGAINST STAFF AND VOLUNTEERS WORKING WITH ADULTS

BSAB Procedure
If you are concerned about staff or volunteers who work with adults, and you wish to seek advice, please contact the Safeguarding Adults Team (MASH) on:

T: 0800 137 915
E: safeguardingadults@buckscc.gov.uk

If an adult with care and support needs has been harmed by a member of staff or volunteer, or you believe that there is a risk of an adult succumbing to harm, you must contact the Safeguarding Adults Team.

Managing Concerns or Allegations Against Staff and Volunteers Working with Adults Who Have Care and Support Needs

Safe Working Practice:
The information and documents below relate to Safe Working Practice in Buckinghamshire.

AMA Safe Working Practice Guidance:

Guidance for Safe Working Practice for adults who work with children and young people

NB: This guidance is dated 2007. The document was reviewed by the BSCB in May 2013 and the content remains up-to-date and relevant.

Safer Recruitment
The information and documents below relate to Safer Recruitment in Buckinghamshire

BSAB/BSCB Safer Recruitment Toolkit
To view the toolkit please click on the link

BSAB/BSCB Safer Recruitment Toolkit
SAFEGUARDING CHILDREN

WHAT TO DO IF THERE ARE CONCERNS RELATING TO A CHILD
In any situation where concerns of abuse or neglect are identified, all persons must give consideration to whether there are any children under the age of 18 years, who may be at risk of harm. If so, Safeguarding Children protocols must be followed. These can be found on the Polices page of the Buckinghamshire Safeguarding Children Board website.

If you need to contact the LADO, please consult the Bucks LSBC, as detailed above.

**If you are concerned about a child:**
- **Call:** 0845 460 0001
- **Email:** secure-cypfirstresponse@bucksc.gc.gov.uk
- **Fax:** 01296 382 207

**Working together to safeguard children - A guide to inter-agency working to safeguard and promote the welfare of children**

The Local Authority Designated Officer (LADO) works within Children’s Services and should be alerted to all cases in which it is alleged that a person who works with children has:

- Behaved in a way that has harmed, or may have harmed, a child.
- Possibly committed a criminal offence against children, or related to a child.
- Behaved towards a child or children in a way that indicates (s)he is unsuitable to work with children.

In the event that any allegations of abuse or neglect are made about a person who works with children (including volunteers), organisational responsibilities for managing these allegations are set out in ‘Working Together to Safeguarding Children 2015’. This can be found on the link below:
RECORD KEEPING
AND SHARING

HOW TO USE AND SHARE INFORMATION SAFELY

› INFORMATION GOVERNANCE
› DUTY OF CANDOUR
› INFORMATION SHARING
› CONFIDENTIALITY
› DATA PROTECTION
› RECORD KEEPING
› PROFESSIONAL
ACCOUNTABILITY
› SUBJECT DATA & FREEDOM
OF INFORMATION REQUESTS
› AN ADULT'S LEGAL RIGHT TO
MAKE THEIR OWN DECISIONS
› WHEN AN ADULT DOES NOT
WANT INFORMATION SHARED
AND THERE IS A PROFESSIONAL
RESPONSIBILITY TO DO SO
› WHERE AN OFFENCE MAY HAVE
BEEN COMMITTED
› ADULTS WHO LACK CAPACITY
TO MAKE RELEVANT DECISIONS
› CAPACITY FORMS
People have a right to know how information will be used and the right to restrict the use of information when exercising choice and control over how they are safeguarded. This may impact on the service that they are offered but it is their right to make an informed choice.

Information Governance is subject to a range of legislation, in particular the:

- Local Government Act 1970
- Data Protection Act 1998
- Human Rights Act 1998
- Public Interest Disclosure Act 1998
- Freedom of Information Act 2000
- Mental Capacity Act 2005 & 2007
- Health and Social Care Act 2008
- The Local Authority Social Services and National Health Services Complaints (England) (Amendment) Regulations 2009

- Practitioners might be mindful that the information that they collect is lawful and that people are routinely informed about why the information is collected, what will be done with the information and who it is likely to be shared with.

- Information management requires organisations to have policies and procedures in line with the above. Each organisation might have information governance arrangements to be followed by all staff and any breach reported to managers and ultimately to the ‘Caldecott Guardian’ where there is one.
Whilst the new Duty of Candour has been in force since the end of November 2014 for NHS providers, from 1st April 2015 there is a new Duty of Candour to which all social care providers in particular must adhere.

This provides that where a notifiable safety incident occurs within a service, there are certain notification requirements which must be followed. The Regulations prescribe the definition of a notifiable safety incident and steps which must be taken.

It is essential that all providers review systems and processes to ensure any notifiable safety incidents would be captured, and that staff have been trained so as to ensure the duty of candour is followed and implemented in applicable circumstances.

- Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level or its equivalent, such as a governing body.

- Providers should have policies and procedures in place to support a culture of openness and transparency, and ensure that all staff follow them.

- Providers should take action to tackle bullying and harassment in relation to duty of candour, and must investigate any instances where a member of staff may have obstructed another in exercising their duty of candour.

- Providers should have a system in place to identify and deal with possible breaches of the professional duty of candour by staff who are professionally registered, including the obstruction of another in their professional duty of candour. This is likely to include an investigation and escalation process that may lead to referral to their professional regulator or other relevant body.

- Providers should make all reasonable efforts to ensure that staff operating at all levels within the organisation operate within a culture of openness and transparency, understand their individual responsibilities in relation to the duty of candour, and are supported to be open and honest with patients and apologise when things go wrong.
DUTY OF CANDOUR

- Staff should receive appropriate training, and there should be arrangements in place to support staff who are involved in a notifiable safety incident.
- In cases where a provider is made aware that something untoward has happened, they should treat the allegation seriously, immediately consider whether this is a notifiable safety incident and take appropriate action.

As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

- provide an account, which to the best of the health service body’s knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,
- advise the relevant person what further enquiries into the incident the registered person believes are appropriate,
- include an apology, and
- be recorded in a written record which is kept securely by the registered person.

For further information see
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20
Information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation. In this context ‘organisations’ mean not only statutory organisations but also voluntary and independent sector organisations, housing authorities, the police and Crown Prosecution Service, and organisations which provide advocacy and support. Decisions about what information is shared and with whom will be taken on a case-by-case basis. Whether information is shared with or without the consent of the adult at risk, the information shared should be:

- necessary for the purpose for which it is being shared
- shared only with those who have a need for it
- be accurate and up to date
- be shared in a timely fashion
- be shared accurately
- be shared securely

There are only a limited number of circumstances where it would be acceptable not to share information pertinent to safeguarding with relevant safeguarding partners. These would be where the person involved has the mental capacity to make the decision and does not want their information shared AND:

- nobody else is at risk
- no serious crime has been or may be committed
- the alleged abuser has no care and support needs
- no staff are implicated
- no coercion or duress is suspected
- the public interest served by disclosure does not outweigh the public interest served by protecting confidentiality
- the risk is not high enough to warrant a multi-agency risk assessment conference referral
- no other legal authority has requested the information

If there is reluctance from one partner to share information on a safeguarding concern the matter should be referred to the Safeguarding Adults Board. It can then consider whether the concern warrants a request, under Clause 45 of the Care Act, for the ‘supply of information’. Then the reluctant party would only have grounds for refusal if it would be ‘incompatible with their own duties or have an adverse effect on the exercise of their functions’.

Reference should be made to local information sharing leads and the local Safeguarding Adults Board Information-Sharing Protocols where they apply. Additional information can be obtained from HM Government (2008) - Information sharing – guidance for practitioners and managers and Information Commissioner’s Office www.ico.gov.uk
Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information, based on the welfare of the adult or of other potentially affected adults. Any agreement should be consistent with the principles set out in the Caldecott Review published 2013 ensuring that:

• Information will only be shared on a ‘need to know’ basis when it is in the interests of the adult.

• Confidentiality must not be confused with secrecy.

• Informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement.

• It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.

Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (e.g. because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldecott Guardian should be involved.

Principles of confidentiality designed to safeguard and promote the interests of an adult should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the welfare of an adult. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of the adult then a duty arises to make full disclosure in the public interest.

In certain circumstances, it will be necessary to exchange or disclose personal information which will need to be in accordance with the law on confidentiality and the Data Protection Act 1998 where this applies.
The Data Protection Act 1998 applies to all organisations in the UK that processes personal information. The Act goes hand-in-hand with the common law duty of confidence and professional and local confidentiality codes of practice to provide individuals with a statutory route to monitor the use of their personal information.

A breach of one of the eight Data Protection Principles can result in legal action being taken against an individual and/or the organisation.

1. Processed fairly and lawfully
2. Processed for the specified purpose(s) for which it was obtained.
3. Adequate, relevant and not excessive for the purpose(s) for which it was obtained
4. Accurate and, where necessary, kept up to date
5. Not kept for longer than is necessary for the purpose(s) for which it was obtained
6. Processed in accordance with rights of data subjects
7. Appropriate measures taken against accidental loss, destruction, or damage (e.g. security)
8. Not transferred outside the European Economic Area unless adequately protected

The rights of adults at risk, and people alleged to have caused harm including providers are upheld under the Data Protection Act. This means that people have the

- Right of access to personal information held about them
- Right to prevent processing likely to cause damage or distress
- Right to have inaccurate data about them corrected, blocked or erased
- Right to prevent processing of information about themselves for purposes of direct marketing

Applying the data protection principles to the safeguarding principles means that people should be advised at the earliest opportunity of any safeguarding concerns.
Where an assessment has taken place, as a result of, or in parallel to safeguarding, individuals must be given a record of their needs or carer’s assessment. A copy must also be shared with anybody else at the individuals’ request. Staff should be given clear direction as to what information should be recorded and in what format. Records should be kept in such a way that the information can easily be collated for local use and national data collections. Organisations will have their own recording systems for keeping comprehensive records whenever there are Safeguarding Adults procedures. At a there should be an audit trail of:

- Date and circumstances of concerns and subsequent action
- Decision making processes and rationales
- Risk assessments and risk management plans
- Consultations and correspondence with key people
- Advocacy and support arrangements
- Safeguarding plans
- Outcomes
- Feedback from the adult and their personal support network
- Differences of professional opinion

Records may be disclosed in courts in criminal or civil actions. They may also be required if a regulatory authority decides to take legal action against a provider. Records kept by Providers should be available to commissioners and the Regulator.
Every time a record is made of a conversation, observation, telephone call, assessment, professionals should quality assure their own work so it measures up to good Information Governance:

- Accurate,
- Contains up to date details
- Contemporaneous
- Discerns fact from opinion
- Compliant with legislation
- Thorough and relevant

Professionals should be confident that if the service user/Provider were to view the record, it would be (a) evidence based (b) written in a professional and respectful manner (c) is compliant with relevant legislation. The following questions are a guide:

- What information do staff need to know in order to provide a high quality response
- What information do staff need to keep adults safe
- What information is not necessary?
- What is the basis for any decision to share (or not) information with a Third Party?

Care should be taken to avoid personal opinion and comments. There is a risk that that this type of recording is seen at a later date as fact which cannot be evidenced. Accuracy is essential, not only for effective safeguarding but ensures resources are not wasted. Using abbreviations is unacceptable unless there is an explanation. Copying of medical notes for example ‘R. sided CVA’ can waste time and impact on the ability to protect someone. Noting that the person has had a stroke and finds it difficult to talk on the telephone is relevant and provides information that is easily understood by everyone.
A judgement framework needs to consider facts, how different types of evidence can be corroborated and how information can support a reasonable and rational assessment. Checking with the adult at risk for accuracy is good practice.

Assessments are an on-going process and therefore there is a need to ensure that information is up to date. Ensuring only one record for one person may be part of auditing. Managers might note any concerns where there are duplicate records and implement an immediate action for data cleansing.

When working with providers, it should be borne in mind that they are reliant upon reputation for their business. Accurate recording that can be backed up by examples and corroborated enables defensible practice.

All records are subject to the retention guidelines set out by the organisation. Through the auditing process records may be disposed of according to each organisations policy. Electronic records should be updated and maintained according to the policy.
Records may be called upon to respond to a subject data or freedom of information request. Additionally, where there is a complaint about a service, or any other type of investigation, records need to be accessible. In the case of requests under either the Data Protection or Freedom of Information Acts, professionals may want to consider the following:

1. Inform the data controller/manager and/or information governance manager/officer know when a request under the Data Protection Act (Subject Data Requests) or Freedom of Information Act requests are received.

2. There is a statutory time frame for response required, 40 days for DPA and 20 days for FOI.

3. If professionals believe that it is inappropriate to provide information to the requestor, the reason for doing so must be submitted to the person managing such requests, who will be in the best position to advise whether an exemption under the Acts is applicable.

4. Always acknowledge a request:  
   - Advising of the time frame for a response  
   - Summary of the information request (this is evidence that you have understood and are acting on this request)

5. Professional judgements of risk to ensure the best interest of adults at risk are maintained. Where an adult at risk has made the request, this should be met as soon as possible and may involve the advocate, or any other person that they wish to be informed and involved.

6. The Information Commissioner will always err on the side of share/provide information unless there is a valid reason not to.
The Mental Capacity Act 2005 sets out in law each person’s rights regarding making their own decisions, and protects their rights regarding this in law. Where a person is unable to make a specific decision for themselves, the Act sets out a clear process that must be followed before a decision can be made on their behalf;

- People must be assumed to have capacity to make their own decisions and be given all practicable help before anyone treats them as not being able to make their own decisions;

- Where an adult is found to lack capacity to make a decision, any action taken, or any decision made for or on their behalf must be made in their best interests;

- Professionals and other staff need to understand and always work in line with the Mental Capacity Act 2005 (MCA). They should use their professional judgement and balance many competing views;

- Employers should provide considerable guidance and support to ensure that professionals and other staff are able to help adults manage risk in ways and put the adults in control of decision making if possible;

- Regular face-to-face supervision from skilled managers is essential to enable staff to work confidently and competently in difficult and sensitive situations.
WHEN AN ADULT DOES NOT WANT INFORMATION SHARED AND THERE IS A PROFESSIONAL RESPONSIBILITY TO DO SO

Where an adult with capacity to make an informed decision about their own safety does not want any action taken, this does not override a professional’s responsibility to raise a safeguarding concern and to share key information with relevant professionals in the circumstances outlined above.

If there appears to be significant risk to the adult, and no one else, consideration would need to be given to whether their wishes should be overridden. The adult’s wishes should not stop professionals from fulfilling their responsibilities in relation to duty of care regarding appropriate sharing of information.

In these situations the adult must always be:

- Advised about what information will be shared, with whom and the reasons for this;
- Advised that their views and wishes will be respected as far as possible by the local authority or other agencies in relation to any response they may have a duty to make;
- Provided with information regarding what happens when a local authority is advised of a safeguarding concern;
- Assured by the professional passing this information to the local authority, that their lack of consent to the information being shared, and their views and wishes regarding actions they do or do not want taken in relation to the situation as far as it affects them directly will also be explained to the local authority.

Professionals should be alert to the risk of situational incapacity, where a person who would otherwise have capacity no longer has it due to their circumstances.
WHERE AN OFFENCE MAY HAVE BEEN COMMITTED

If it is suspected that an offence may have been committed, there should always be a conversation with the adult regarding whether they wish the police to be involved. If the adult does not want the police to be involved this does not override a professional’s responsibility to share information regarding a potential or actual offence with them.

Such situations should always be approached sensitively. The adult should be advised that the police will be contacted, and assured that the police will be informed that they do not wish to pursue this matter or speak to the police. It is for the police to determine if they feel it is necessary for them to speak to the adult, or if there is further action they may need to pursue.
ADULTS WHO LACK CAPACITY TO MAKE RELEVANT DECISIONS

If the adult lacks capacity to make informed decisions about the incident and their ability to maintain their safety and they do not want a safeguarding concern to be raised, and / or other action to be taken, professionals have a duty to act in their best interests under the Mental Capacity Act 2005. This requires a Best Interest decision to be made regarding whether a safeguarding concern should be raised.

Adults who lack capacity need to be supported to be able to make informed choices if possible before a decision can be made and a best interest decision made on their behalf. This may be achieved in a variety of ways such as the help of a family member or friend (as long as they are not the person thought to be the cause of risk), an Advocate or Independent Mental Capacity Advocate, a language interpreter or other communication assistance or aid.
CAPACITY FORMS

Referral for an IMCA form
CASE STUDIES

STORIES WHICH DEMONSTRATE HOW SAFEGUARDING IS USED IN PRACTICE
**CASE STUDIES**

Two brothers with mild learning disabilities lived in their family home, where they had remained following the death of their parents some time previously. Large amounts of rubbish had accumulated both in the garden and inside the house, with cleanliness and self-neglect also an issue. They had been targeted by fraudsters, resulting in criminal investigation and conviction of those responsible, but the brothers had refused subsequent services from adult social care and their case had been closed.

They had, however, had a good relationship with their social worker, and as concerns about their health and wellbeing continued it was decided that the social worker would maintain contact, calling in every couple of weeks to see how they were, and offer any help needed, on their terms. After almost a year, through the gradual building of trust and understanding, the brothers asked to be considered for supported housing; with the social worker’s help they improved the state of their house enough to sell it, and moved to a living environment in which practical support could be provided.

Ref: Care and support statutory guidance Updated: 25 April 2016
Mrs B is an 88 year old woman with dementia who was admitted to a care home from hospital following a fall. Mrs B appointed her only daughter G, to act for her under a Lasting Power of Attorney in relation to her property and financial affairs.

Mrs B’s former home was sold and she became liable to pay the full fees of her care home. Mrs B’s daughter failed to pay the fees and arrears built up, until the home made a referral to the local authority, which in turn alerted the Office of the Public Guardian (OPG).

The OPG carried out an investigation and discovered that G was not providing her mother with any money for clothing or toiletries, which were being provided by the home from its own stocks. A visit and discussion with Mrs B revealed that she was unable to participate in any activities or outings arranged by the home, which she dearly wished to do. Her room was bare of any personal effects and she had limited stocks of underwear and nightwear.

The Police were alerted and interviewed G, who admitted using the proceeds of the mother’s house for her own benefit. The OPG applied to the Court of Protection for suspension of the power of attorney and the appointment of a deputy, who was able to seek recovery of funds and ensure Mrs B’s needs were met.

Ref: Care and support statutory guidance Updated: 25 April 2016
Mr A is in his 40s, and lives in a housing association flat, with little family contact. His mental health is relatively stable, following a previous period of hospitalisation and he has visits from a mental health support worker.

He rarely goes out, but he allows people into his accommodation because of his loneliness. The police were alerted by Mr A’s neighbours to several domestic disturbances. His accommodation had been targeted by a number of local people and he had become subjected to verbal, financial and sometime physical abuse. Although Mr A initially insisted they were his friends, he did indicate he was frightened; he attended a case conference with representatives from adult social care, mental health services and the police, from which emerged a plan to strengthen his own self-protective ability as well as to deal with the present abuse.

Mr A has made different arrangements for managing his money so that he does not accumulate large sums at home. A community-based visiting service has been engaged to keep him company through visits to his home, and with time his support worker aims to help get involved in social activities that will bring more positive contacts to allay the loneliness that Mr A sees as his main challenge.

Ref: Care and support statutory guidance Updated: 25 April 2016
Mrs D lives with her husband, B. B has a long term brain injury which affects his mood, behaviour and his ability to manage close family relationships. This has often led to him shouting and hitting out at his wife, who is also his main informal carer. Mrs D told a professional who was involved in supporting her that she was becoming increasingly frightened by B’s physical and verbal outbursts and at times feared for her personal safety.

Other family members were unaware of the extent of the harm and that Mrs D was exhausted and considering leaving the situation. The local authority became involved. The situation presented significant personal risk to Mrs D but there was also a risk of fragmenting relationships if the local authority staff were not sensitive to the needs of the whole family. The practitioner, under supervision from her social work manager invested time in meeting with Mrs D to explore her preferences around managing her safety and how information about the situation would be communicated with the wider family and with B. This presented dilemmas around balancing the local authority’s duty of care towards Mrs D with her wishes to remain in the situation with B. Placing emphasis on the latter inevitably meant that Mrs D would not be entirely free from the risk of harm but allowed the practitioner to explore help and support options which would enable Mrs D to manage and sustain her safety at a level which was acceptable to her.

The practitioner received regular supervision to allow time to reflect on the support being offered and to ensure that it was ‘person centred’. The outcome for Mrs D was that she was able to continue to care for B by working in partnership with the local authority. The practitioner offered advice about how to safely access help in an emergency and helped her to develop strategies to manage her own safety – this included staff building rapport with B, building on his strengths and desire to participate in social activities outside the family home. The effect of this was that some of the trigger points of him being at home with his wife for sustained periods during the day were reduced because he was there less.

Mrs D also had a number of pre-existing support avenues, including counselling and a good relationship with her son and her friends. The situation will be reviewed regularly with Mrs D but for the time being she feels much more able to manage.

Ref: Care and support statutory guidance Updated: 25 April 2016
CASE STUDIES

PREVENTING ABUSE AND NEGLECT
Case study

Miss P’s mental health social worker became concerned when she had received reports that 2 of Miss P’s associates were visiting more regularly and sometimes staying over at her flat. Miss P was being coerced into prostitution and reportedly being physically assaulted by one of the men visiting her flat. There was also concern that she was being financially exploited. Miss P’s lack of understanding of how to protect herself when living alone was exacerbated by her mental health needs and consequent inability to set safe boundaries with the people she was associating with.

The social worker recognised that the most appropriate way to enable Miss P to manage the risk of harm was to involve Miss P’s family, which she agreed to, and other professionals to develop and coordinate a plan which would enable her to continue living independently but provide a safety net for when the risk of harm became heightened. Guided initially by Miss P’s wish for the 2 men to stay away from her, the social worker initiated a planning meeting between supportive family members and other professionals such as the police, domestic violence workers, support workers and housing officers. Although Miss P herself felt unable to attend the planning meeting, her social worker ensured that her views were included and helped guide the plan. The meeting allowed family and professionals to work in partnership, to openly share information about the risks and to plan what support Miss P needed to safely maintain her independence.

Tasks were divided between the police, family members and specialist support workers. The social worker had a role in ensuring that the plan was coordinated properly and that Miss P was fully aware of everyone’s role. Miss P’s family were crucial to the success of the plan as they had always supported her and were able to advocate for her needs.

They also had a trusting relationship with her and were able to notify the police and other professionals if they thought that the risk to Miss P was increasing. The police played an active role in monitoring and preventing criminal activity towards Miss P and ensured that they kept all of the other professionals and family up to date with what was happening. Miss P is working with a domestic violence specialist to help her develop personal strategies to keep safer and her support worker is helping her to build resilience through community support and activities.

Ref: Care and support statutory guidance Updated: 25 April 2016
CASE STUDIES

CRIMINAL OFFENCES AND ADULT SAFEGUARDING
Case study

Miss Y is a young woman with a learning disability with limited support from her family and was not engaged with health and social care services. Miss Y was befriended by an individual who took her to parties where she was given drugs and alcohol and forced to have sex with different men. Sometimes she would be given money or gifts in return for having sex with the men.

Miss Y disclosed this to a social worker and it was discovered that there were a number of young people and vulnerable adults who were being sexually exploited by multiple perpetrators. Miss Y lacked mental capacity in order to be able to consent to having sex, as well as in relation to her accommodation, finances or personal safety.

The perpetrators sought out Miss Y and others because of their perceived vulnerability – whether that was because of their isolated situation and social circumstances coupled with age, disability, mental illness, or their previous history as a victim of abuse. The process to safeguard Miss Y involved a coordinated response between the police, social care, health and voluntary and community sector organisations.

This included the police investigating the perpetrators for rape, sexual assault, trafficking and drug offences. The Court of Protection and Deprivation of Liberty Safeguards were also used initially to safeguard Miss Y.

Ref: Care and support statutory guidance Updated: 25 April 2016
CASE STUDIES

CRIMINAL OFFENCES AND ADULT SAFEGUARDING

Case study

Mr P has mild learning disabilities. The safeguarding concern was financial and other abuse and neglect by his brother, with whom he lived. His support worker had noticed that Mr P had begun to appear agitated and anxious, that he looked increasingly unkempt and that he was often without money; then he suddenly stopped attending his day centre.

When the support worker and the safeguarding officer followed up, Mr P told them that at times he was not allowed out at all by his brother and was confined to his bedroom. He was only allowed to use the bathroom when his brother said he could, and often didn’t get enough to eat. He was also very worried because his bank card no longer worked, and he had no money, so couldn’t buy food for himself.

Mr P consented to move to temporary accommodation, and a case conference was held, which he attended with an advocate. At his request a move to a supported living flat was arranged and his belongings were retrieved from his brother’s property. His bank account had been emptied by his brother, so he has made new arrangements for his money.

The police are investigating both the financial abuse and the harm Mr P suffered at his brother’s hands. He has begun to talk about his experiences and is gradually regaining his confidence.

Ref: Care and support statutory guidance Updated: 25 April 2016
Mr A is 24 and has autism and a mild learning disability. He is a very friendly and sociable young man, who is prone to waving and talking to most people he comes across and who sees everyone as a potential friend. However, he struggles to read the intentions of others and is easily led astray and manipulated.

He lives next door to a pub, where he knows the staff and the regulars. He also lives close to his GP and is able to access his most frequently visited places. He does, however, like to walk into town to talk to people he meets out and about. On such occasions he has been repeatedly tricked into stealing items from a newsagent by a group of teenagers and given large amounts of money away to strangers he strikes up conversations with. Due to his previous experiences, Mr A was identified during a needs assessment as being at risk of abuse and neglect and a safeguarding enquiry was triggered.

The council found that, although Mr A was not currently experiencing abuse or neglect, he remained highly vulnerable to abuse due to his being well-known in his area as someone as easy to manipulate.

To assure his safety in the future, a safeguarding plan was agreed between Mr A and a social worker. This focused on developing his social skills and understanding of relationships and boundaries and the social worker worked with Mr A to consider various support options such as having a buddy or circle of support.

The social worker put Mr A in touch with an autism social group which provided sessions on skills for staying safe. As the group was based in town, Mr A’s plan also included a support worker to accompany him. After the first 5 sessions Mr A was able to attend himself but continued to meet with his support worker on a monthly basis as part of the risk management strategy set out in his safeguarding plan.

Ref: Care and support statutory guidance Updated: 25 April 2016
Recent research has identified ways of working that can have positive outcomes for those who self-neglect.

Mr M, in his 70s, lives in an upper-floor council flat, and had hoarded over many years: his own possessions, items inherited from his family home, and materials he had collected from skips and building sites in case they came in useful. The material was piled from floor to ceiling in every room, and Mr M lived in a burrow tunnelled through the middle, with no lighting or heating, apart from a gas stove. Finally, after years of hiding in privacy, Mr M had realised that work being carried out on the building would lead to his living conditions being discovered. Mr M himself recounted how hard it had been for him to invite access to his home, how ashamed and scared he was, and how important his hoard was to him, having learnt as a child of the war never to waste anything.

Through working closely together, Mr M, his support worker and experienced contractors have been able gradually to remove from his flat a very large volume of hoarded material and bring improvements to his home environment. It has taken time and patience, courage and faith, and a strong relationship based on trust. The worker has not judged Mr M, and has worked at his pace, positively affirming his progress. Both Mr M and his support worker acknowledge his low self-esteem, and have connected with his doctor and mental health services. The worker has recognised the need to replace what Mr M is giving up, and has encouraged activities that reflect his interests. Mr M has valued the worker’s honesty, kindness and sensitivity, his ability to listen and the respect and reciprocity within their relationship.

Ref: Care and support statutory guidance Updated: 25 April 2016
CASE STUDIES

LEARNING FROM REVIEW
Case study

At the age of 72 years, Ms W, although registered disabled, was an active member in her community often seen helping at community events and visiting the local shops and swimming pool. Ms W had a fall in her home which left her lacking in confidence and fearful that she would fall again. As the winter approached, Ms W spent more time alone at home only venturing to the corner shop to buy groceries. As time passed her house came in disrepair and unhygienic as local youths began throw rubbish, including dog faeces into her front garden.

Within a 5 month period Ms W made 7 complaints to the police about anti-social behaviour in her local area, and on 2 occasions she was the victim of criminal damage to the front of her house, where her wheelchair accessibility ramp has been painted by graffiti. The police made a referral to social services. As a result, Ms W was placed on a waiting list for a support service.

Four weeks after she was last seen Ms W committed suicide. A Serious Case Review (SCR) was convened according to the local policy that stated ‘the purpose of an SCR is not to reinvestigate or to apportion blame, but to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults. The published report and recommendations which followed demonstrated the lessons from this case. The resultant action plan included:

- strengthened relationships and information sharing between police officers, health and the local authority
- clear lines of reporting and joint working arrangements with the community safety partnerships
- a robust multi-agency training plan
- a targeted community programme to address anti-social behaviour
- the development of a ‘people’s panel’ as a sub group to the Safeguarding Adults Board which includes people who access services, carers and voluntary groups
- the development of a ‘stay safe’ programme involving local shops where adults at risk of abuse may report their concerns to a trusted member if their community

Ref: Care and support statutory guidance Updated: 25 April 2016
CASE STUDIES

A resident at a local care home told the district nurse that staff members spoke disrespectfully to her and that there were episodes of her waiting a long time for the call bell to be answered when wanting to use the commode. The resident wished to leave the home as she was very unhappy with the treatment she was receiving, and was regularly distressed and tearful.

The resident was reluctant for a formal safeguarding enquiry to take place, but did agree that the issues could be discussed with the manager. The district nurse negotiated some actions with the manager to promote good practice and address the issues that had been raised. When the district nurse reviewed the situation; the manager at the care home had dealt with the issues appropriately and devised an action plan. The resident stated that she was now happy at the care home – staff "couldn't be more helpful" - and she no longer wanted to move.

Ref: Care and support statutory guidance Updated: 25 April 2016
SAFEGUARDING UNDER THE CARE ACT (2014) | ABUSE AND NEGLECT | MULTI AGENCY PROCEDURES | ROLES AND RESPONSIBILITIES | LEGISLATION AND GUIDANCE | SAFEGUARDING CHILDREN | RECORD KEEPING AND SHARING | CASE STUDIES | FORMS | GLOSSARY | INDEX

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FORMS

Safeguarding Adults Referral Form

Deprivation of Liberty Safeguards (DoLS)

Domestic Abuse, Stalking and Honour Based Violence (DASH), Risk Identification
GLOSSARY

DESCRIPTION OF SOME OF THE KEY WORDS USED IN SAFEGUARDING

Safeguarding
Multi agency
Personalisation
Section 42 Enquiry
Provider
Commissioner
### GLOSSARY

<table>
<thead>
<tr>
<th>Terminology</th>
<th>Replaces (where relevant)</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding concern</td>
<td>Alert</td>
<td>Levels no longer apply. Nature of concern / risk and outcomes the adult wants to achieve informs what is the most appropriate and proportionate response to the concern e.g. causing an enquiry to be made by another organisation / agency.</td>
</tr>
<tr>
<td>Three key tests in the Care Act</td>
<td>N / A</td>
<td>Three key tests in relation to adults covered by the safeguarding procedures. The safeguarding duties apply to an adult who:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Has needs for care and support (whether or not the local authority is meeting any of those needs).</td>
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<tr>
<td></td>
<td></td>
<td>• Is experiencing, or is at risk of, abuse or neglect.</td>
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<tr>
<td></td>
<td></td>
<td>• As a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect.</td>
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<tr>
<td></td>
<td></td>
<td>Once the local authority has reasonable cause to believe an adult meets this test its Section 42 duty is triggered. The local authority may still decide to undertaken an enquiry where the three tests in the Care Act are not met</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NB. Carers are also covered by the procedures where they meet the three tests set out above.</td>
</tr>
</tbody>
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### GLOSSARY

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</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding enquiry</td>
<td>Investigation</td>
<td>An ‘enquiry’ is any first action taken in response to a safeguarding concern to establish whether the local authority’s Section 42 duty has been triggered, i.e. the three tests in the Care Act have been met. There is a move away from investigations (except by the police and where disciplinary investigations are undertaken by employers).</td>
</tr>
<tr>
<td>Section 42 enquiry</td>
<td>Investigation</td>
<td>The local authority must make or cause other agencies or organisations to make enquiries when its Section 42 duty is triggered, i.e. when it has reasonable cause to believe that the three tests in the Care Act have been met.</td>
</tr>
<tr>
<td>Initial Enquiry, First Response</td>
<td>N / A</td>
<td>Any first responses made under the local authority’s Section 42 duty to make enquiries / cause enquiries to be made. NB. A conversation with the adult should always be the first response (or one of the first, responses, if they have not already been spoken with).</td>
</tr>
<tr>
<td>Conclusion of an enquiry</td>
<td>N / A</td>
<td>The local authority’s Section 42 duty of enquiry continues until it has decided what action is necessary to protect the adult, and by whom, and has ensured that this action has been taken.</td>
</tr>
<tr>
<td>Terminology</td>
<td>Replaces (where relevant)</td>
<td>Definition</td>
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</tr>
<tr>
<td>S 42 enquiries stage 1 and 2</td>
<td>N / A</td>
<td>If the issue cannot be resolved through the actions taken in the initial response to the safeguarding concern the local authority’s duty under Section 42 continues until it decides what action is necessary to protect the adult, and by whom, and ensures itself that this action has been taken.</td>
</tr>
<tr>
<td>Responsible Manager (EM)</td>
<td>Investigation Manager</td>
<td>A suitably trained and experienced practitioner employed by the local authority with responsibility for decision making in relation Section 42 enquiries.</td>
</tr>
<tr>
<td>Lead Enquiry Officer (EO)</td>
<td>Investigation Officer</td>
<td>A suitably trained and skilled practitioner undertaking an enquiry or aspects of an enquiry.</td>
</tr>
<tr>
<td>Designated Adult Safeguarding Manager (DASM)</td>
<td>N / A (this is a new role)</td>
<td>The local authority and each member of the Safeguarding Adults Board (BSAB) should have a DASM responsible for the management and oversight of individual complex cases and coordination where allegations are made or concerns raised about a person, whether an employee, volunteer or student, paid or unpaid, who may have harmed or who may pose a risk to adults. The DASM provides advice and guidance within their organisation, liaising with other agencies as necessary and monitors the progress of cases to ensure they are dealt with as quickly as possible, consistent with a thorough and fair process.</td>
</tr>
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</table>
## GLOSSARY

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults review (SAR)</td>
<td>Serious case reviews</td>
<td>Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of, or has experienced serious abuse or neglect (known or suspected) and there is concern that partner agencies could have worked more effectively together. The aim of the SAR is to identify and implement learning from this.</td>
</tr>
<tr>
<td>The person(s) or service thought to be the cause of risk, or ‘cause of risk’</td>
<td>Person / service alleged responsible</td>
<td>A person, organisation or service who may have some relationship to the cause of risk or issue of concern for the adult.</td>
</tr>
</tbody>
</table>

### Types of abuse

<table>
<thead>
<tr>
<th>Categories of abuse</th>
<th>Institutional abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes neglect and poor practice within an institution or specific care setting, e.g., in a hospital or care home or in relation to care provided in a person’s own home. This may rage from one off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.</td>
<td></td>
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</tbody>
</table>

### Modern slavery

<p>| N / A | Includes slavery, human trafficking, forced labour, and domestic servitude, including inhumane and abusive treatment. |</p>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Domestic abuse</td>
<td>N / A</td>
<td>Note: safeguarding adults procedures are concerned with people aged 18 and over. Domestic violence includes young people aged 16 years and over, however young people are covered by Child Protection procedures.</td>
</tr>
<tr>
<td>Self-neglect</td>
<td>N / A</td>
<td>Self-neglect is now included as a type of abuse under the safeguarding adults procedures. See guidance for working with people who self-neglect.</td>
</tr>
<tr>
<td>Safeguarding meeting</td>
<td>Strategy meeting and case conference</td>
<td>Safeguarding adults work and a ‘making safeguarding personal’ (MSP) approach starts from a point that the adult / their representative will always be included in any discussion or meeting that relates to them.</td>
</tr>
<tr>
<td>Adult</td>
<td>Adult at risk</td>
<td>A person who meets the three key tests set out in the Care Act.</td>
</tr>
<tr>
<td>Harm</td>
<td>N / A</td>
<td>A negative or detrimental impact on an adult’s emotional, physical or mental well-being.</td>
</tr>
<tr>
<td>Making Safeguarding Personal</td>
<td></td>
<td>‘Making safeguarding personal’ means it should be person-led and outcomes focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, well-being and safety. (See MSP Practice Guidance and Toolkit).</td>
</tr>
<tr>
<td>Terminology</td>
<td>Replaces (where relevant)</td>
<td>Definition</td>
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</tbody>
</table>
| Safeguarding plan                                    |                           | Actions / arrangements agreed with the adult to support them in maintaining their safety. These should be incorporated into the adult’s support / care plan where they have one. It should include clear information regarding roles and responsibilities of all those involved and the arrangements for monitoring and reviewing the effectiveness of this plan.  
Where there are actions that relate to the Local Authority and / or other agencies, these should also be recorded.  
While the local authority’s Section 42 duty will be discharged once it has determined that the adult has been protected and / or the actions required have been taken, it must ensure that any actions taken as a result of this process are monitored and kept under review.  
The local authority and other organisations must ensure they have arrangements in place for the effective monitoring and review of these actions.  
This may include actions for agencies and organisations where the adult does not wish to have a safeguarding plan in place. |
| Agencies responsible for commissioning / commissioners |                           | The term ‘commissioning’ or ‘commissioners’ refers to any agency, service or team with a responsibility for commissioning care and support service, including social care, health, housing etc. It includes any commissioning and quality assurance functions, and teams with this function. |
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LIST OF ALL THE SUBJECT HEADINGS USED IN THIS DOCUMENT

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» CARERS
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» LOCAL AUTHORITY DESIGNATED OFFICER (LADO)
» THAMES VALLEY POLICE (TVP)
» CLINICAL COMMISSIONING GROUP (CCG)
» CORONER
» ADVOCATES
  – Independent Mental Capacity Advocate (IMCA)
  – Independent Mental Health Advocacy (IMHA)
  – Independent advocates (substantial difficulty)
» PROVIDER ORGANISATIONS
» BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD
  – Boards must work in partnership
  – Joint systems
  – Safeguarding Adult Reviews
» MULTI AGENCY SAFEGUARDING HUB (MASH)
» ALL PARTNER AGENCIES

LEGISLATION AND GUIDANCE
» TYPES OF ABUSE
  – Physical abuse
  – Domestic abuse
  – Domestic abuse – Forced marriage
  – Domestic abuse – ‘Honour based’ abuse
  – Sexual abuse
  – Psychological abuse
  – Financial or material abuse
  – Modern slavery
  – Discriminatory abuse
  – Organisational abuse
  – Neglect and acts of omission
  – Self-neglect
    – Hoarding
    – Diogenes Syndrome
    – Hoarding - Guidance for Practitioners
    – Morbid Obesity
    – Assessment of self-neglect
    – Mental Capacity and self-neglect
    – Supporting Practitioners working with self-neglect
    – Legal Framework and self-neglect
    – Significant factors in self neglect
    – Indicators of self-neglect
    – RAMP (Risk Assessment &
INDEX

- Management Panel
  - Diversity and self-neglect
  - PREVENT / Radicalisation
  - Channel
  - Multiagency Frameworks
- THE CARE ACT 2014
  - Background
  - Guidance
  - Safeguarding
  - Safeguarding Adults Policies and Procedures
  - Local Safeguarding Adults Procedures that all Partner Agencies and Organisations must have in Place
  - Criminal Justice and Courts Act 2015
- MENTAL CAPACITY AND DEPRIVATION OF LIBERTY
  - Introduction
  - An Adult’s Legal Right to Make their Own Decisions
  - Principles of the Act
  - Mental Capacity and Safeguarding
  - Deprivation of Liberty Safeguards
  - Identifying Deprivation of Liberty
  - Test for Deprivation of Liberty
  - Authorising a Deprivation of Liberty
  - DOLS and Safeguarding
- ADVANCED DECISIONS AND LIVING WILLS
  - Advanced Decisions
  - Advanced Decision
  - Advanced Statement
  - The Mental Health Act 2007 provides
- SAFEGUARDING CHILDREN
- RECORD KEEPING AND SHARING
  - INFORMATION GOVERNANCE
  - DUTY OF CANDOUR
  - INFORMATION SHARING
  - CONFIDENTIALITY
  - DATA PROTECTION
  - RECORD KEEPING
  - PROFESSIONAL ACCOUNTABILITY
  - SUBJECT DATA & FREEDOM OF INFORMATION REQUESTS
  - AN ADULT’S LEGAL RIGHT TO MAKE THEIR OWN DECISIONS
  - WHEN AN ADULT DOES NOT WANT INFORMATION SHARED AND THERE IS A PROFESSIONAL RESPONSIBILITY TO DO SO
  - WHERE AN OFFENCE MAY HAVE BEEN COMMITTED
  - ADULTS WHO LACK CAPACITY TO
- MANAGING ALLEGATIONS AGAINST STAFF AND VOLUNTEERS WORKING WITH ADULTS
- CASE STUDIES
  - MAKING SAFEGUARDING PERSONAL (MSP)
  - FINANCIAL ABUSE
  - SPOTTING SIGNS OF ABUSE AND NEGLECT
  - CARERS AND SAFEGUARDING
  - PREVENTING ABUSE AND NEGLECT
  - CRIMINAL OFFENCES AND ADULT SAFEGUARDING
  - WHO CAN CARRY OUT AN ENQUIRY?
  - SELF NEGLECT – HOARDING
  - LEARNING FROM REVIEW
  - ORGANISATIONAL / INSTITUTIONAL (ABUSE OF RIGHTS) AND/OR CONSTRUED AS POOR PRACTICE
- FORMS
- GLOSSARY

0800 137 915
Each agency has a responsibility to have their own internal safeguarding procedure, which should comply with this multiagency framework, and should clearly set out the responsibilities of all persons who operate within them.

See Roles & Responsibilities - ALL PARTNER AGENCIES