Safeguarding Adults

Procedures for South Yorkshire

Doncaster, Sheffield, Rotherham and Barnsley Councils have a joint responsibility to respond to all matters of Safeguarding Adults.
This document contains the key overarching principles to which the Local Authority will work and are further underpinned by Local Guidance and Procedures.

This document should replace all previous procedures.

Date Procedures agreed	5 October 2015
Review Date	October 2016

Safeguarding Adults

South Yorkshire's Adult Protection Procedures

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Section One

1. The Six Principles of Adult Safeguarding[1]- Section 42-46 of the Care Act 2014

The six key principles that underpin all adult safeguarding work are:

Empowerment
Personalisation and the presumption of person-led 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
Proportionate and least intrusive response appropriate to the risk presented.
"I am sure that the professionals will work for my best interests, 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. I get help to take part in the safeguarding process to the extent to which I want and to which I am able."

Partnership
Providing 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 treats any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me."

Accountability
Accountability and transparency in delivering safeguarding
"I understand the role of everyone involved in my life."
These 6 principal will require evidencing throughout the safeguarding process.

Equally the same 6 principals will require evidencing when undertaking a Safeguarding Adults Review (SAR)

2. Who has Lead Responsibility for Safeguarding?

Everyone has a responsibility to ensure that a concern about the alleged abuse of an Adult at Risk is addressed.

The Care Act 2014 places the lead responsibility for managing adult safeguarding within the 'Local Authority' working with the police who will lead on any criminal concerns relating to an Adult at Risk.

In addition the 'Act' places a 'duty to co-operate' on the Safeguarding Adults Board members and requires other organisations to work in partnership with the Board.

If disagreement between agencies exists about the most appropriate way to conduct the S42 enquiry and this cannot be resolved via discussions, the following policy should be used to resolve the issues also see local policy where developed

(**https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf**

Professional Resolution Policy.doc

3. Who does this procedure cover?

An adult aged 18 or over whose care and support needs/circumstances meet the three stage test below

4. The 3 Stage test for a 'Safeguarding Enquiry'

The safeguarding duties apply to an adult who:

1. Has needs for care and support (whether or not the local authority is meeting any of those needs)

2. Is experiencing, or at risk of, abuse or neglect

3. As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

5. Confidentiality

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 Caldicott 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; and 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 Caldicott Guardian should be involved.

Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework.

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.

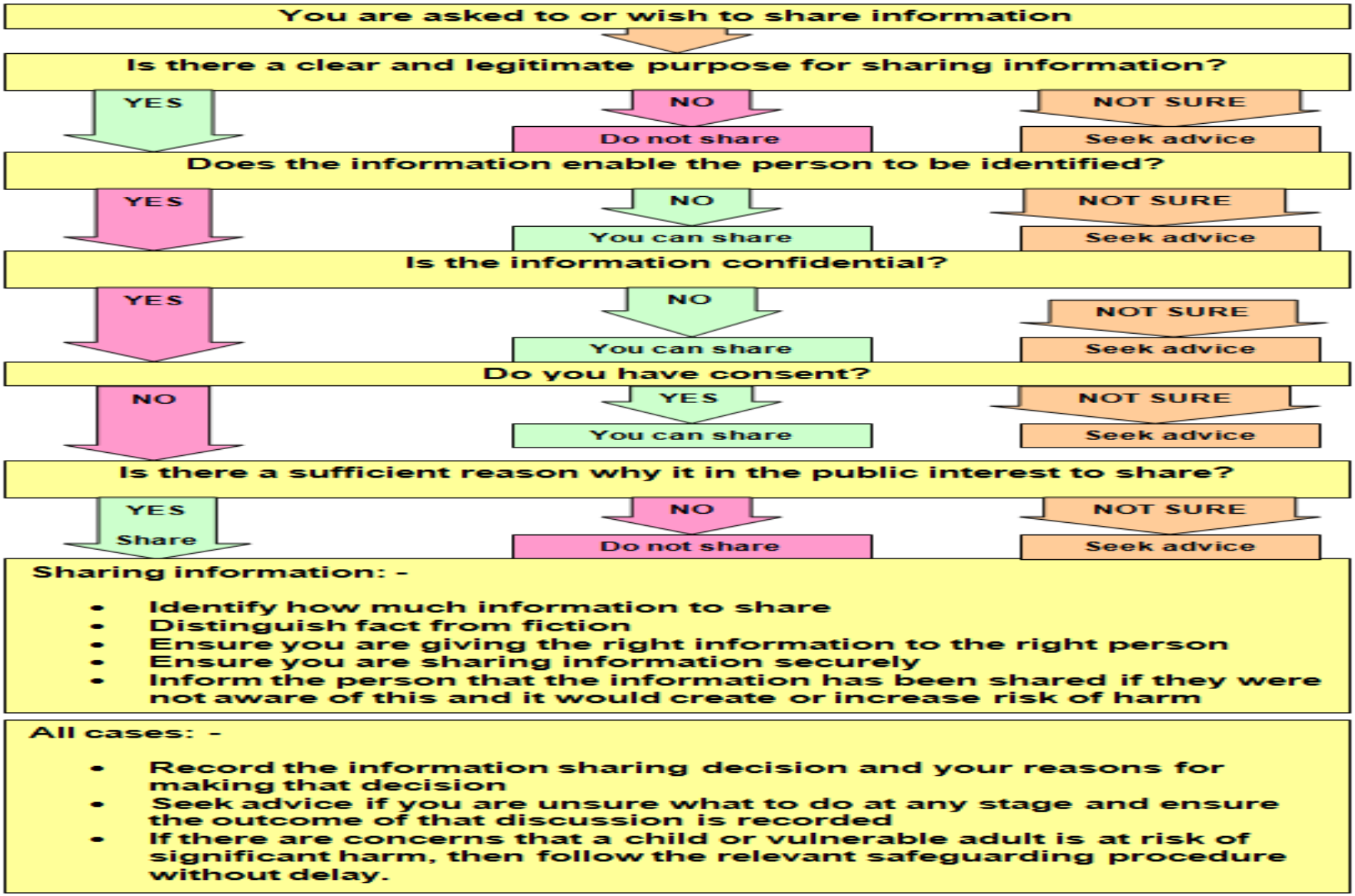
In certain circumstances, it will be necessary to exchange or disclose personal information, which will need to be in accordance with the law on confidentiality and the Data Protection Act 1998 where this applies.

See also: **Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers, HM Government March 2015. Document found at (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf).**

See Appendix 1 for full information on sharing information

Flowchart of Key Questions for Information Sharing

The flowchart below has been reproduced here with the kind permission of Hull Safeguarding Adults Boar



Key Questions for Information Sharing

6. Mental Capacity

Does the Adult at Risk lack specific capacity to make a decision– is there a Best Interest Decision required?

The Mental Capacity Act 2005 (MCA 2005) is designed to protect and restore power to adults who may lack or have reduced Capacity to make certain decisions at certain times. 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. An individual is deemed to lack Capacity if at the time, a decision is required, and he/she is unable to make that decision because of an impairment or disturbance in the functioning of the mind or brain. This may be temporary or permanent.

The following 5 principles apply for the purposes of this Act:

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

The Functional Test of Capacity;

In order to decide whether an individual has the mental capacity to make a particular decision you must decide whether there is an impairment of, or disturbance in, the functioning of the person’s mind or brain.

The person will be unable to make a particular decision if after all the appropriate help and support to make the decision has been given to them; they cannot do the following things.

1. Understand the information relevant that decision
2. Retain the information
3. Use or weigh the information as part of the process or making the decision
4. Communicate their decision by any means

Best Interests;

If an assessment of capacity concludes that the person lacks the mental capacity to make the relevant decision, the decision maker must consider the following key factors in determining what is in the person's best interests;

1. Likelihood of regaining capacity
2. Relevant circumstances
3. Participation of the individual
4. Past and present wishes
5. Views of others
6. Beliefs and values
7. Consideration of life sustaining treatment.
8. Not making judgements based on a person's age, gender disability etc.
9. Least restrictive alternative

Deprivation of Liberty Safeguards

This amendment to the Mental Capacity Act 2005 (introduced by the Mental Health Act 2007) is to provide for procedures to authorise the deprivation of liberty of a person in a hospital or care home who lacks Capacity to consent to being there. These are known as the MCA Deprivation of Liberty Safeguards (MCA DoLS). 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.

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) (http://www.legislation.gov.uk/ukpga/2005/9/contents) can be lawfully carried out in someone's best interest to prevent harm. This includes use of physical restraint where that is proportionate to the risk of harm to the person and in line with best practice. Neither the Mental Capacity Act nor DoLS can be used to justify the use of restraint for the protection of members of staff or other service users or patients.

The difference between restriction of movement and deprivation of liberty is based on degree and intensity.

DoLS is relevant in Care Home and Hospital settings however a person can be deprived of their liberty in other settings too. In those other settings and application to the Court of Protection is required instead.

Revised Test for Deprivation of Liberty

The Supreme Court has clarified (P v Cheshire West and Chester Council and P&Q v Surrey County Council, March 2014) that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights where the person:

- Is under continuous supervision and control.
- Is not free to leave.
- Lacks Capacity to consent to these arrangements.

Mental Capacity and Safeguarding

Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the MCA in adult Safeguarding Enquiries challenges many professionals and requires utmost care, particularly where it appears an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected.

Ill Treatment and Willful Neglect
The MCA created the criminal offences of ill treatment and willful neglect in respect of people who lack the ability to make decisions, however this legislation was amended to include people who are capacitated (link to legislation). The offences can be committed by anyone responsible for that adult's care and support - paid staff but also family carers as well as 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 also those acts that are reckless which results in ill treatment.

Willful 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.

See Appendix 4: For full Guidance on MCA and Deprivation of Liberty Safeguards

7. Under Duress or Coercive Control

The Adult at Risk has capacity however you suspect they are under duress or is under coercive control?

Undue Influence

The concept of 'undue influence' applies where a person has capacity to conduct a financial or property transaction (usually related to gifts or wills), but they have been not just influenced but, unduly influenced by someone else. If there is evidence of coercion or undue pressure, this is known as 'express undue

influence'. Usually there is no such evidence, but there may have been 'presumed undue influence applied. '

There are three initial points in relation to undue influence:

a) The unduly influenced person has mental Capacity to take the decision in question;
b) The person is influenced to enter into a transaction concerning a gift or will, in such a way that it is not of his or her own free will;
c) There are two legal types of undue influence. One is called 'express' undue influence that applies to both gifts and wills; the other is called 'presumed' undue influence and applies to gifts only' Consent should not therefore always be accepted at face value, since some adults may need protection from emotional manipulation and exploitation.

In addition to undue influence, the courts can simply set aside gifts or wills on the grounds that the person lacked capacity at the relevant time.

In Domestic Violence/ Abuse the experience of duress and coercive control can be of a similar in nature:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

In the announcement, the government defines controlling and coercive behaviour in the following way:

*"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." **

This definition, which is not a legal definition, includes 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Controlling or Coercive behaviour in an intimate or family relationship is now a criminal offence, which may result in imprisonment for up to 5 years or a fine or both. (See guidance for Serious Crime Act 2015 Section 76)

8. Main Categories of Abuse

The Care Act 2014 identifies a number of different types and patterns of **Abuse** and **Neglect** and the circumstances in which they may take place.

It is important to note that professionals should not limit their view on what constitutes abuse or neglect, as they can take many forms and the circumstances and wishes of the individual **must** always be considered.

Incidents of abuse may be one-off or multiple, and affect one person or more.

Professionals and others should look beyond single incidents or individuals to identify patterns of harm, just as the Care Quality Commission, as the regulator of service quality, does when it looks at the quality of care in health and care services. Repeated instances of poor care may be an indication of more serious problems and of what the Care Act now describes as organisational abuse (See **Organisational Abuse, previously known as Institutional Abuse)**.

All concerns must be logged with the Local Authority, even if they don't result in a S42 enquiry to enable the Local Authority to map a picture of the risks/practice in that particular organisation.

Forms of Abuse

This section sets out the different types and patterns of abuse and neglect as identified within the Care Act 2014.

It is not intended to be an exhaustive list but an illustrative guide as to the sorts of behaviour, which could give rise to safeguarding concerns.

Other circumstances may constitute abuse or neglect and are identified in the related chapter below.

RELATED LEGISLATION

The Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

RELATED GUIDANCE

Care and Support Statutory Guidance, DH, October 2014 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf)

Reporting and Responding to Abuse and Neglect

It is important to understand the circumstances of abuse, including the wider context such as whether others may be at risk of abuse, whether there is any emerging pattern of abuse, whether others have witnessed abuse and the role of family members and paid staff or professionals.

The circumstances surrounding any actual or suspected case of abuse or neglect will inform the response. For example, it is important to recognise that abuse or neglect may be unintentional and may arise because a carer is struggling to care for another person. This makes the need to take action no less important, but in such circumstances, an appropriate response could be a support package for the carer and monitoring. However, the primary focus must still be how to safeguard the adult. In other circumstances where the safeguarding concerns arise from abuse or neglect deliberately intended to cause harm, then it would not only be necessary to immediately consider what steps are needed to protect the adult but also whether to refer the matter to the police to consider whether a criminal investigation would be required or appropriate.

Early sharing of information is the key to providing an effective response where there are emerging concerns (See **Information Sharing and Confidentiality Procedure**). No professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or, the police if they believe or suspect that a crime has been committed.

Patterns of Abuse

Patterns of abuse and abusing vary and reflect very different dynamics. These include:

- **Serial abuse** in which the source of harm seeks out and 'grooms' individuals. Sexual exploitation sometimes falls into this pattern as do some forms of financial abuse;
- **Long-term abuse** in the context of an on-going family relationship such as domestic violence between spouses or generations or persistent psychological abuse; or
- **Opportunistic abuse** such as theft occurring because money or jewellery has been left lying around.

Who abuses and neglects adults?

Anyone can abuse or neglect adults including:

- Spouses/partners.
- Other family members.
- Neighbours.
- Friends.
- Acquaintances.
- Local residents.
- People who deliberately exploit adults they perceive as vulnerable to abuse.
- Paid staff or professionals and
- Volunteers and strangers.

Where does abuse take place?

Abuse can happen anywhere: for example, in someone's own home, in a public place, in hospital, in a care home or in college. It can take place when an adult lives alone or lives with others.

While a lot of attention is paid, for example to targeted fraud or internet scams perpetrated by complete strangers, it is far more likely that the person responsible for abuse is known to the adult and is in a position of trust and power.

Definitions and indicators of Abuse

The categories of abuse are;

Physical Abuse

Physical Abuse is the non-accidental infliction of physical force that results (or could result) in bodily injury, pain or impairment.

Examples of physical abuse include:

- Assault;
- Hitting;
- Slapping;
- Pushing;
- Kicking;
- Pinching;

- Shaking;
- Scalding.

Physical abuse can also include:

- Misuse of medication;
- Prolonged exposure to heat or cold;
- Force feeding;
- Not giving/withholding adequate food or drink.

Potential indicators of physical abuse include:

- Unexplained or inappropriately explained injuries;
- Person exhibiting untypical self-harm;
- Unexplained cuts or scratches to mouth, lips, gums, eyes or external genitalia;
- Unexplained bruising to the face, torso, arms, back, buttocks, thighs, in various stages of healing. Collections of bruises that form regular patterns which correspond to the shape of an object or which appear on several areas of the body;
- Unexplained burns on unlikely areas of the body (e.g. soles of the feet, palms of the hands, back), immersion burns (from scalding in hot water/liquid), rope burns, burns from an electrical appliance;
- Unexplained or inappropriately explained fractures at various stages of healing to any part of the body;
- Medical problems that go unattended;
- Sudden and unexplained urinary and/or faecal incontinence;
- Evidence of over/under medication;
- Person flinches at physical contact;
- Person appears frightened or subdued in the presence of particular people;
- Person asks not to be hurt;
- Sudden weight loss or weight gain;
- Person may repeat what the alleged abuser has said (e.g. ‘Shut up or I’ll hit you’);
- Reluctance to undress or uncover parts of the body.

Restraint

Unlawful or inappropriate use of restraint or physical interventions is physical abuse.

In extreme circumstances, unlawful or inappropriate use of restraint may constitute a criminal offence. Someone is using restraint if they use force, or threaten to use force, to make someone do something they are resisting, or

where a person's freedom of movement is restricted, whether they are resisting or not.

Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something, or does not do something they want to do, for example, the use of key pads to prevent people from going where they want from a closed environment.

Appropriate use of restraint can be justified to prevent harm to a person who lacks capacity as long as it is a proportionate response to the likelihood and seriousness of the harm.

See local links to restraint policies and mental health codes of practice on restraint and restrictive practice

Psychological Abuse

Psychological abuse (sometimes called Emotional Abuse) is behaviour that has a harmful effect on the adult's emotional health, well-being and development. It is the denial of a person's human and civil rights including choice and opinion, privacy and dignity and being able to follow one's own spiritual and cultural beliefs or sexual orientation.

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

Examples of Psychological Abuse include:

- Threats of harm or abandonment;
- Deprivation of contact;
- Humiliation or blaming;
- Controlling;
- Intimidation;
- Cyber bullying;
- Coercion;
- Indifference;
- Harassment;
- Verbal abuse (including shouting or swearing); and
- Isolation or withdrawal from services or support networks.

Potential indicators of psychological abuse include:

- Untypical ambivalence, deference, passivity, resignation anger and depression;
- Person appears anxious or withdrawn, especially in the presence of the alleged abuser;
- Person exhibits low self-esteem;
- Untypical changes in behaviour (e.g. continence problems, sleep disturbance);
- Person is not allowed visitors/phone calls;
- Person is locked in a room/in their home;
- Person is denied access to aids or equipment, (e.g. glasses, dentures, hearing aid, crutches, etc.);
- Person's access to personal hygiene and toilet is restricted;
- Person's movement is restricted by use of furniture or other equipment;
- Bullying via social networking, internet sites and persistent texting.

Financial or Material Abuse

Financial abuse is the main form of abuse investigated by the Office of the Public Guardian involving both adults and children. Financial recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Whilst this is not always the case, staff and volunteers need to aware of and vigilant to this.

Examples of Financial/Material Abuse include:

- Theft;
- Fraud;
- Exploitation;
- Pressure in connection with wills, property or inheritance or financial transactions; or
- The misuse or misappropriation of property, possessions or benefits.

It also includes the withholding of money or the unauthorised or improper use of a person's money or property, usually to the disadvantage of the person to whom it belongs.

Staff borrowing money or objects from a service user is also considered financial abuse.

Potential indicators of financial/material abuse include:

- Lack of heating, clothing or food;
    - Inability to pay bills/unexplained shortage of money;
    - Change in living conditions

- Unexplained withdrawals from accounts;
    - Unexplained loss/misplacement of financial documents;
    - The recent addition of authorised signers on a client or donor's signature card;

- Disparity between assets/income and living conditions;
- Power of attorney obtained when the person lacks the Capacity to make this decision;
- Sudden or unexpected changes in a will or deeds/title of house or other financial documents;
- Recent acquaintances expressing sudden or disproportionate interest in the person and their money;

- Service user not in control of their direct payment or individualised budget;
- Mis-selling/selling by door-to-door traders/cold calling;
- Illegal money-lending.
- 'Mate' Crime
- Goods, Services being bought that the person has no use for.

Financial abuse has the potential to significantly threaten an adult's health and well-being.

The following case study, taken from the **DH Care and Support Statutory Guidance, October 2014** (**https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf**
Highlights the need for local authorities not to underestimate the potential impact of financial abuse:

Most financial abuse may be theft or fraud and so would be a matter for the police to investigate. It may also require attention and collaboration from a wider group of organisations, including shops and financial institutions such as banks.

Where the abuse is by someone who has the authority to manage an adult's money, the relevant body should be informed, for example, the Office of the Public Guardian for deputies and **Department for Work and Pensions (DWP)** in relation to appointees.

If there are concerns that a DWP appointee is acting incorrectly, the DWP should be contacted immediately. In addition to a name and address the DWP can act

more quickly if it also has a National Insurance number. If the DWP know that the person is also known to the local authority then they should also inform them.

Undue Influence

The concept of 'undue influence' applies where a person has capacity to conduct a financial or property transaction (usually related to gifts or wills), but they have been not just influenced, but unduly influenced by someone else. If there is evidence of coercion or undue pressure, this is known as 'express undue influence'. Usually there is no such evidence, but there may have been 'presumed undue influence. '

There are three initial points in relation to undue influence:

a) The unduly influenced person has mental **Capacity** to take the decision in question;
b) The person is influenced to enter into a transaction concerning a gift or will, in such a way that it is not of his or her own free will;
c) There are two legal types of undue influence. One is called 'express' undue influence that applies to both gifts and wills; the other is called 'presumed' undue influence and applies to gifts only' Consent should not therefore always be accepted at face value, since some adults may need protection from emotional manipulation and exploitation.

In addition to undue influence, the courts can simply set aside gifts or wills on the grounds that the person lacked capacity at the relevant time.

Neglect and Acts of Omission

Neglect is the failure of any person who has responsibility for the charge, care or custody of an adult to provide the amount and type of care that a reasonable person would be expected to provide.

Behaviours that can lead to neglect 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 (this may also constitute physical abuse if the person's physical health is adversely affected).

Neglect also includes a failure to intervene in situations that are dangerous to the person concerned or to others, when the person lacks the mental capacity to assess risk for themselves.

Neglect and poor professional practice may take the form of isolated incidents or pervasive ill treatment and gross misconduct. Repeated instances of poor care may be an indication of more serious problems.

Neglect can be intentional or unintentional.

Potential indicators of Neglect and Acts of Omission include:

- Person has inadequate heating and/or lighting;
- Person's physical condition/appearance is poor (e.g. ulcers, pressure sores, soiled or wet clothing);
- Person is malnourished, has sudden or continuous weight loss and/or is dehydrated;
- Person cannot access appropriate medication or medical care;
- Person is not afforded appropriate privacy or dignity;
- Person and/or a carer has inconsistent or reluctant contact with health and/or care and support services;
- Callers/visitors are refused access to the person;
- Person is exposed to unacceptable risk.

Discriminatory Abuse

The principles of Discriminatory Abuse are embodied in legislation including the following:

Race Relations Act 1976 (Amendments) Regulations 2003
http://www.legislation.gov.uk/ukdsi/2003/0110461835/contents

Disability Discrimination Act 1995
http://www.legislation.gov.uk/ukpga/1995/50/contents

Human Rights Act 1998 http://www.legislation.gov.uk/ukpga/1998/42/data.pdf

This type of Abuse is motivated by discriminatory and oppressive attitudes towards people on the grounds of disability, gender and gender identity and reassignment, age, race, religion or belief, sexual orientation, and political beliefs.

It may be a feature of any form of abuse and manifests itself as physical abuse/assault, sexual abuse/assault, financial abuse/theft, neglect and psychological abuse/harassment. It includes verbal abuse and racist, sexist, homophobic or ageist comments, or jokes or any other form of harassment. It also includes not responding to dietary needs and not providing appropriate spiritual support.

Examples of Discriminatory Abuse include:

- Unequal treatment;
- Verbal abuse;
- Inappropriate use of language;
- Slurs;
- Harassment;
- Deliberate exclusion
- Anti-social behaviour - hate incidents and hate crime, see Anti-social Behaviour Act 2003 http://www.legislation.gov.uk/ukpga/2003/38/contents and, Other Forms of Abuse Procedure, Hate Crime.

Potential indicators of Discriminatory Abuse include:

- A person may reject their own cultural background and/or racial origin or other personal beliefs, sexual practices or lifestyle choices;
- A person making complaints about the service not meeting their needs;
- Lack of respect shown to an individual;
- Signs of a sub-standard service offered to an individual;
- Repeated exclusion from rights afforded to citizens such as health, education, employment, criminal justice and civic status;
- Failure to follow the agreed care plans can result in the adult being placed at risk.

Organisational Abuse (previously known as Institutional Abuse)

Organisational Abuse includes neglect and poor care practice within an institution or specific care setting such as a hospital or care home or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment.

It may be a result of regimes, routines, practices and behaviours that occur in services that adults live in or use and which violate their human rights. This may be part of the culture of a service to which staff are accustomed and may pass by unremarked upon. They may be subtle, small and apparently insignificant, yet together may amount to a service culture that denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of individuals.

Organisational Abuse is most likely to occur when staff:

- Receive little support from management;
- Are inadequately trained;
- Are poorly supervised and poorly supported in their work;
- Receive inadequate guidance.

The risk of abuse is also greater in services:

- With poor management;
- With too few staff;
- Which use rigid routines and inflexible practices;
- Which do not use a person-centred approach;
- Where there is a closed culture;
- Where there are inadequate quality assurance and monitoring systems in place.

Potential indicators of Organisational Abuse include:

- Unnecessary or inappropriate rules and regulations;
- Lack of stimulation or the development of individual interests;
- Inappropriate staff behaviour, such as the development of factions, misuse of drugs or alcohol, failure to respond to leadership;
- Restriction of external contacts or opportunities to socialise;
- Staff attitudes, where staff may view clients negatively, treating them like children, not involving them in making choices as they seem too confused or disabled. Staff may think that if clients do not appear to understand then they can talk in front of them as if they are not there.

Staffing Issues

Abuse is more likely to occur in services where staffing levels are insufficient to provide appropriate and timely intervention required to meet the complete range of physical and social needs.

Routines can become too set and rigid and may be fixed around the needs of staff, e.g. bathing routines, bedtimes set around the staff rotas and not around the individual.

Other circumstances that my increase the risk of abuse include:

- Lack of choice and consultation: about social needs, personal care needs and, activities, for example;
- Lack of personal belongings: lack of personal care items, shared toiletries, bulk-buying of personal care items, lack of personal clothing.
- Task-focused: where staff are focused on getting the job done rather than spending time with client.
- Lack of staff training: staff does not have the required knowledge/skills to provide care. No training or inadequate training has been provided.
- Staff Morale: staff can feel undervalued, may lack supervision or training.
- Poor staff conditions: staff can experience work-place stress, which is not being addressed by colleagues and their manager. Low staff self-esteem can lead to an environment in which abuse becomes the norm.

- Policies and procedures: Care Plans do not reflect the needs and wishes of the service users. Care Plan evaluation and record keeping do not contain evidence of implementation of care.
- Poor recruitment procedures leading to inappropriate appointments, for example appointing staff with convictions for theft.
- Lack of Compliance with MCA and DoLs.

The nature and timing of the intervention and who is best placed to lead will be, in part, determined by the circumstances. For example, where there is poor, neglectful care or practice, resulting in pressure sores for example, then an employer-led disciplinary response may be more appropriate; but this situation will need additional responses such as clinical intervention to improve the care given immediately and a clinical audit of practice. Commissioning or regulatory enforcement action may also be appropriate.

Environment

Environmental factors may also increase the risk of abuse, for example:

- The care environment is not suited to care or is unsafe, i.e. during building works rendering the area not compliant with Health and Safety legislation;
- The environment is dirty and does not comply with hygiene /control and infection standards.

Sexual Abuse

Sexual abuse is the direct or indirect involvement in sexual activity without **Consent**. This could also be the inability to consent, pressure or induced to consent or take part. Sexual abuse includes rape, indecent assault, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts to which the adult has not consented or was pressured into consenting.

This also includes the involvement of an adult in sexual activity or relationships, which they cannot understand, or have been coerced into because the other person is in a position of trust, power or authority (e.g. day centre worker, residential worker/health worker etc.)

Denial of a sexual life to consenting adults is also considered abusive practice.

Potential Indicators of sexual abuse include:

- Person has urinary tract infections, vaginal infections or sexually transmitted infections that are not otherwise explained;
- Person appears unusually subdued, withdrawn or has poor concentration;

- Person exhibits significant changes in sexual behaviour or outlook;
- Person experiences pain, itching or bleeding in the genital/anal area;
- Person's underclothing is torn, stained or bloody;
- A woman who lacks the mental capacity to consent to sexual intercourse becomes pregnant.
- Bruising to genitals, anus, breast or arms and legs indicating restraint.
- Damage to mouth, abrasions and tears.
- Safeguarding adults from sexual exploitation

This section is based on information available in relation to child sexual exploitation, yet much of this information is pertinent to adults who may be at risk of being sexually exploited. It relates to adults who may be exploited due to a learning or physical disability for example. It also relates to young people who have transferred from Children's Services to Adult Services who have previously been sexually exploited.

Introduction

Sexual exploitation takes different forms - from a seemingly 'consensual' relationship where sex is exchanged for attention, affection, accommodation or gifts, to serious organised crime and human trafficking. Sexual exploitation involves differing degrees of abusive activities, including coercion, intimidation or enticement, unwanted pressure from peers to have sex, sexual bullying (including cyber bullying), and grooming for sexual activity. There is increasing concern about the role of technology in **Sexual Abuse**, including via social networking and other internet sites and mobile phones. The key issue in relation to the sexual exploitation of adults is the imbalance of power within the 'relationship'. The source of harm always has power over the Adult at Risk, increasing the dependence of the Adult at Risk as the exploitative relationship develops.

Adults may be groomed into sexually exploitative relationships but other forms of entry exist. Some are engaged in informal economies that incorporate the exchange of sex for rewards such as drugs, alcohol, money or gifts. Others exchange sex for accommodation or money as a result of homelessness and experiences of poverty. Some Adults have been bullied and threatened into sexual activities by peers or gangs, which are then used against them as a form of extortion and to keep them compliant.

They may have already been sexually exploited before being referred to the Safeguarding Adults process; others may become targets of the source of harm whilst living at home or during placements in care settings. They are often the focus of perpetrators of Sexual Abuse due to their vulnerability. All staff and carers should therefore create an environment which educates adults about sexual exploitation, involving relevant outside agencies where appropriate. They

should encourage them to discuss any such concerns with them, another member of staff, or with someone from a specialist sexual exploitation project, and also feel able to share any such concerns about their friends.

Indicators of Possible Sexual Exploitation

Staff and carers should receive training on sexual exploitation, and therefore be aware of the key indicators. These include:

Health

- Physical symptoms (bruising suggestive of either physical or sexual assault);
- Chronic fatigue;
- Recurring or multiple sexually transmitted infections;
- Pregnancy and/or seeking an abortion;
- Evidence of drug, alcohol or other substance misuse;
- Sexually risky behaviour.

Education

- Truancy/disengagement with education or considerable change in performance at school.
- Emotional and Behavioural Issues
- Volatile behaviour exhibiting extreme array of mood swings or use of abusive language;
- Involvement in petty crime such as shoplifting, stealing;
- Secretive behaviour;
- Entering or leaving vehicles driven by unknown adults;
- Reports of being seen in places known to be used for sexual exploitation, including public toilets known for cottaging or adult venues (pubs and clubs).

Identity

- Low self-image, low self-esteem, self-harming behaviour, e.g. cutting, overdosing, eating disorder, promiscuity.

Relationships

- Hostility in relationships with staff, family members as appropriate and significant others;
- Physical aggression;

- Placement breakdown;
- Reports from reliable sources (e.g. family, friends or other professionals) suggesting the likelihood of involvement in sexual exploitation;
- Detachment from age-appropriate activities;
- Associating with other young people who are known to be sexually exploited;
- Known to be sexually active;
- Sexual relationship with a significantly older person, or younger person who is suspected of being abusive;
- Unexplained relationships with older adults;
- Possible inappropriate use of the Internet and forming relationships, particularly with adults, via the Internet;
- Phone calls, text messages or letters from unknown adults;
- Adults or older youths loitering outside the home;
- Persistently missing, staying out overnight or returning late with no plausible explanation;
- Returning after having been missing, looking well cared for in spite of having no known home base;
- Missing for long periods, with no known home base;
- Going missing and being found in areas where they have no known links.

Please note: Whilst the focus is often on older men as sources of harm, younger men and women may also be involved and staff should be aware of this possibility.

Social Presentation

- Change in appearance;
- Going out dressed in clothing unusual for them (inappropriate for age, borrowing clothing from older young people).

Family and Environmental Factors

- History of physical, sexual, and/or emotional abuse; neglect; domestic violence; parental difficulties.

Housing

- Pattern of previous street homelessness;
- Having keys to premises other than those known about.

Income

- Possession of large amounts of money with no plausible explanation;

- Acquisition of expensive clothes, mobile phones or other possessions without plausible explanation;
- Accounts of social activities with no plausible explanation of the source of necessary funding.

This list is not exhaustive.

Staff and carers should be aware that adults who are sexually exploited may not see themselves as victims. In such situations, discussions with them about concerns should be handled with great sensitivity. Seeking prior advice from specialist agencies may be useful. This should not involve disclosing personal, identifiable information at this stage.

In assessing whether an adult is a victim of sexual exploitation, careful consideration should be given to the issue of consent. It is important to bear in mind that:

- Non-consensual sex is rape whatever the age of the victim.
- If the victim is incapacitated through drink or drugs, or the victim or his or her family has been subject to violence or the threat of it, they cannot be considered to have given true consent; therefore offences may have been committed;
- The sexual exploitation of adults is therefore potentially a safeguarding adults issue.

The sexual exploitation training staff and carers receive should also include what information should be given to the police in such cases, for example vehicle registration numbers, names, physical descriptions. It may also include what action staff should take in the case of suspected sexual or physical abuse in order to protect potential evidence, which may be useful in the case of an alleged source of harm being prosecuted.

Referring Cases of Concern

Where a member of staff or carer is concerned that an Adult at Risk is involved in, or at risk of, sexual exploitation, they should contact their Safeguarding Adult Lead, as outlined in **Stage One - Raising a concern/Duty to Enquire Procedure**. The allocated social worker should also be informed, if there is one.

Staff or carers should also contact the police, if they are concerned a crime has been, or may be, committed.

Carers should also contact their social worker / support agency at the earliest opportunity or for advice if they first want to discuss their concerns.

If the adult is not deemed to be at risk of, or is being sexually exploited, the central contact team where safeguarding concerns are reported to should

consider onward referral to relevant agencies. This should include liaison with the member of staff or carer who made the referral.

Supporting Adults out of Sexual Exploitation

Staff from statutory agencies and voluntary sector organisations together with the adult, carers, and his / her family as appropriate, should agree on the services which should be provided to them and how they will be coordinated. The types of intervention offered should be appropriate to their needs and should take full account of identified risk factors and their individual circumstances. This may include, for example, previous abuse, missing incidents, involvement in gangs and groups and/or human trafficking. Health services provided may include sexual health services and mental health services. Advice should be sought from the nearest specialist service, which works with adults involved in sexual exploitation. A referral should be made as appropriate, if the adult is in agreement. Because of the lasting effects of sexual exploitation, support may be required over a long period of time.

Identifying and Prosecuting Sources of Harm

The police and criminal justice agencies lead on the identification and prosecution of sources of harm. All practitioners, however, have a role in gathering, recording and sharing information with the police and other agencies, as appropriate and in agreement with them.

Staff and carers should bear in mind that sexual exploitation often does not occur in isolation and has links to other crime types, including:

- Sexual violence in intimate relationships;
- Grooming (both online and offline);
- Abusive sexual images and their distribution (organised abuse);
- Organised sexual abuse, including of children;
- Drugs-related offences (dealing, consuming and cultivating);
- Gang-related activity (see also Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEGG) **http://www.childrenscommissioner.gov.uk/info/csegg1**
- Children's Commissioner, 2013.
- Immigration-related offences.
- Domestic servitude.

Supporting Adults through Related Legal Proceedings

Where alleged sources of harm are arrested and charged with offences against adult's allocated staff and carers should ensure they are supported throughout the prosecution process and beyond. Specialist agencies should be involved in supporting the adult, as required. This may include using special measures to protect them when giving evidence in court for example. Independent Sexual

Violence Advisers or specialist voluntary sector services, if available, may also have an important role to play.

Self- Neglect

This covers a wide range of behaviours including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Safeguarding partnerships can be a positive means of addressing issues of self-neglect. The Safeguarding Adults Board is a multi-agency group that is the appropriate forum where strategic discussions can take place on dealing with what are often complex and challenging situations for practitioners and managers as well as communities more broadly. Recent research has identified ways of working that can have positive outcomes for those who self - neglect.

See: **A Scoping Study of Workforce Development for Self-Neglect Work, Skills for Care, October 2013** **http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Research/Self-Neglect-Final-Report-301013-FINAL.pdf**

Below is a case study taken from the **Department of Health Guidance: Care and Support Statutory Guidance, October 2014** **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf** which demonstrates how agencies can work together, using a sensitive and caring approach to address the issue of hoarding:

Spotting Signs of Abuse and Neglect

Workers across a wide range of organisations need to be vigilant about adult safeguarding concerns in all walks of life including, amongst others in health and social care, welfare, policing, banking, fire and rescue services and trading standards; leisure services, faith groups, and housing. GPs, in particular, are often well-placed to notice changes in an adult that may indicate they are being abused or neglected. The role of the public and the community should not be dismissed in that they also can play a part in identifying concerns. (See Case Study below).

Findings from Serious Case Reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, then death or serious harm might have been prevented.

The following case study, taken from The Department of Health Guidance: **Care and Support Statutory Guidance** **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf**

issued under the Care Act 2014, October 2014 illustrates the important role that the community (in this case a neighbour) plays in identifying when an adult is at risk.

Anyone can witness or become aware of information suggesting that abuse and neglect is occurring. The matter may, for example, be raised by a worried neighbour (see above case study), a concerned bank cashier, a GP, a welfare benefits officer, a housing support worker or a nurse on a ward.

Primary care staff may be particularly well placed to spot abuse and neglect, as in many cases they may be the only professionals with whom the adult has contact. The adult may say or do things that hint that all is not well. It may come in the form of a complaint, a call for a police response, an expression of concern, or come to light during a needs assessment.

Regardless of how the safeguarding concern is identified, everyone should understand what to do, and where to go locally to get help and advice. It is vital that professionals, other staff and members of the public are vigilant on behalf of those unable to protect themselves. This will include:

- Knowing about different types of abuse and neglect and their signs;
- Supporting adults to keep safe;
- Knowing who to tell about suspected abuse or neglect; and
- Supporting adults to think and weigh up the risks and benefits of different options when exercising choice and control.

Awareness campaigns for the general public and multi-agency training for all staff will contribute to achieving these objectives.

The following categories of abuse have dedicated services and processes in place to respond, however, a joint response with Safeguarding may be required.

Domestic Violence

See also: **Adult Safeguarding and Domestic Abuse: A Guide to Support Practitioners and Managers (LGA and ADASS)**
http://www.local.gov.uk/c/document_library/get_file?uuid=5928377b-8eb3-4518-84ac-61ea6e19a026&groupId=10180

Domestic Violence and Abuse, Home Office https://www.gov.uk/domestic-violence-and-abuse

With effect from March 2013, the official Government definition of domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *Psychological;*
- *Physical;*
- *Sexual;*
- *Financial;*
- *Emotional.*

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."

This definition includes 'honour based' violence, female genital mutilation (FGM) and forced marriage (See Other Forms of Abuse Procedure), and is clear that victims are not confined to one gender or ethnic group.

The majority of domestic abuse is committed by men towards women. It can also involve men being abused by their female partners, abuse in same sex relationships, and by young people towards other family members, as well as the abuse of older people in families. Domestic abuse occurs irrespective of social class, racial, ethnic, cultural, religious or sexual relationships or identity.

No one agency can address all the needs of people affected by, or perpetrating, domestic violence and abuse. For intervention to be effective agencies and partner organisations need to work together, and be prepared to take on the challenges that domestic violence and abuse creates.

The Domestic Violence Disclosure Scheme (Claire's Law) went live nationwide on 08 March 2014, giving members of the public a 'right to ask' Police where they have a concern that their partner may pose a risk to them or where they are concerned that the partner of a member of their family or a friend may pose a risk to that individual. To access this information an application must be made in person at a police station

Managing Risk and Levels of Intervention

The **Domestic Abuse and Harassment and Honour Based Violence (DASH) Identification and Risk Assessment Model.**
http://www.dashriskchecklist.co.uk/

The aim of this model is to save lives through early risk identification, intervention and prevention, and to create one standard practical tool to refer cases to the **Multi-Agency Risk Assessment Conference (MARAC)**, to share information and manage risk effectively - See also **Multi-Agency Risk Assessment Conferences Procedure**.

The **Association of Chief Police Officers (ACPO) http://www.acpo.police.uk/** Council accredited this model to be implemented across all police services in the UK from March 2009.

- The DASH model is for all professionals working with victims of domestic abuse, stalking and harassment and honour based violence;
- In England and Wales, the police service use the ACPO DASH and partner agencies the Safe Lives DASH;
- There is also a risk checklist for victims of domestic abuse, stalking and honour based violence. This is called the **Victim - DASH (V-DASH 2010) http://www.dashriskchecklist.co.uk/index.php?page=v-dash-for-victims**
- There are also further questions on stalking called the **Stalking - DASH (S-DASH, 2009) http://www.dashriskchecklist.co.uk/index.php?page=s-dash-for-use-in-stalking-cases-by-practitioners** Risk Identification Checklist. This again has been adapted for victims to use, **Victim Stalking - DASH (VS-DASH 2009) http://www.dashriskchecklist.co.uk/index.php?page=vs-dash-for-use-in-stalking-cases-by-victims**

The police have to ask the ACPO DASH questions at all incidents and grade them standard, medium or high risk. The first response officer will conduct the initial risk identification and then the specialist staff based in the domestic abuse unit will then conduct the risk assessment in full. The risk tool for police is more extensive covering a full risk assessment and risk management packages, as well as three explicit additional questions relating to children, 11 on stalking and harassment and a further 10 if Honour Based Violence is disclosed.

The purpose of the checklist is to give a consistent and practical tool to practitioners working with victims of domestic abuse to help them identify those who are at high risk of harm and whose cases should be referred to **MARAC**.

MARAC CONTACT DETAILS;
E-MAIL.
marac@sheffield.gcsx.gov.uk
MARAC_rotherham@southyorks.pnn.police.uk
MARAC_barnsley@southyorks.pnn.police.uk
marac@doncaster.gcsx.gov.uk
(b) FAX. Send by FAX to 0114 252 3095 or 8095 (Police internal number)
FOR SHEFFIELD: FAX - 0114 2736984

ALL MARAC REFERRALS MUST BE ALSO FORWARDED TO THE LOCAL IDVA SERVICE:
Sheffield - idvas.groupmailbox@sheffdap.cjsm.net Tel: (0114) 249 3920 Fax: 272 4296
Rotherham rotherham.idvas@rotherham.gov.uk.cjsm.net –Fax 01709 371637
Barnsley – kath.huckle@barnsley.cjsm.net Tel/Fax 01226 731812
Doncaster - idvas@doncaster.gcsx.gov.uk Fax 01302 862354

The checklist should be used whenever a professional receives an initial disclosure of domestic abuse. It is designed to be used for those suffering current rather than historic domestic abuse and, ideally, should be used as a rapid response to an incident of abuse.

Forced Marriage – New Offences from 16th June 2014

On **16th June 2014** new legislation becomes effective under the Anti-Social Behaviour, Crime and Policing Act 2014 to make **forcing** someone to marry a criminal offence.

A person who is found guilty of the offence is liable to a fine or imprisonment of 7 years.

It will also be an offence to use deception in order to entice someone abroad so that they can be married against their will. The act will also give protection to those lacking mental capacity to make an informed decision about whether to marry or not.

Definition of Forced Marriage

Forced Marriage is defined as ‘a marriage conducted without the valid consent of one or both parties, where duress is a factor’. Duress can mean emotional pressure as well as criminal actions such as an assault or abduction.

Forced Marriage can have a devastating impact on people’s lives and prospects for the future. Forced Marriage is either child abuse when children are involved or domestic abuse when adults are involved. It may include physical or sexual violence, threatening behaviour, stalking/ harassment, imprisonment, abduction, financial control and other forms of demeaning or humiliating behaviour or control. Victims can be male or female.

A Forced Marriage is **distinctly different** from an Arranged Marriage, which is arranged by families but the choice remains with the individuals who give full and free consent.

The majority of cases of forced marriage encountered in the UK involve South Asian families, but this is due to the size of the South Asian population in the UK, rather than this being an issue specific to this community. There are also cases involving families from Iraqi Kurdistan, East Asia, the Middle Ease, Eastern Europe, Africa and from within Czech and Slovak Roma Communities.

Forced Marriage Protection Orders (FMPO)

Forced Marriage Protection Order is one of the tools that can help protect victims against forced marriage. Police and social workers can help adults to work with solicitors to apply for a Forced Marriage Protection Order. This is a legal document issued by a judge, which is designed to protect the Adult at Risk. It contains legally binding conditions and directions that require a change in the behaviour of a person or persons trying to force another Adult at Risk into marriage.

The aim of the order is to protect the person who has been forced or is being forced into marriage. Orders can be made in an emergency to protect someone straightaway. They can also be made to protect someone when they are a child if there is a risk that a forced marriage could happen in the future.

The Offence of Breaching a Forced Marriage Protection Order

A person who without reasonable excuse does anything that they are prohibited from doing by a Forced Marriage Protection Order is **now** guilty of an offence.

A person guilty of an offence under this section is liable to a fine or 5 years in prison.

Help and advice on Forced Marriage is available.

Domestic Violence Protection Notice and Orders

The new Domestic Violence Protection Notice and Orders legislation came into force on Monday 2nd June 2014 in South Yorkshire.

Domestic violence protection orders are a new power introduced by the **Crime and Security Act 2010**, and enable the police to put in place protection for the victim in the immediate aftermath of a domestic violence incident.

The Domestic Violence Protection Notice (DVPN) allow police officers to act instantly to safeguard you and your children (if you have them) if they consider you to be under threat of domestic abuse – this may be from your partner, husband / wife, boyfriend / girlfriend or a family member. The Orders are used to intervene in cases where police believe someone may be at risk from violence or are worried about violent behaviour within a household, but do not have enough evidence to bring a criminal charge. Within 48 hours of a DVPN being issued, there is a hearing in the Magistrates' court where the Police can apply for the notice to be made into an order (Domestic Violence Protection Order – or DVPO) and the length of the order is determined – this can be for up to 28 days.

The new measures give police the power to ban someone who is being violent to their partner or other family member from their homes for a length of time decided through the magistrates' court (between 14 and 28 days). The order allows the Adult at Risk to stay in their own home rather than have to flee themselves (e.g. to a friend's home, or a refuge), to escape the abuser. This is intended to give you vital respite and time to consider your options. You will be given information about local support agencies that can provide assistance to you and help you consider your options e.g. whether you want to secure a longer-term injunction against the person who is abusing you.

A Domestic Violence Protection Notice can contain details such as telling the person who is being abusive not to text, call, write, email or 'Facebook' you. If the person being abusive to you lives at your address it will do the following:

- Prohibit them from evicting or excluding you
- Prohibit them from entering the address
- Require them to leave the address
- Prohibit them from coming within a specified distance of you.

The Police may arrest the abuser without a warrant if the police believe that they have breached the Domestic Violence Protection Order.

A breach of the order by the abuser can result in a fine from **£50 to £5,000 or imprisonment** for up to 2 months.

For more information see http://www.southyorks.police.uk/news-syp/domestic-violence-protection-orders-used-across-south-yorkshire

Case Study

Marie Smith (23) lives at home with her mother and brother, her father left the household many years ago and he has no contact with the family
Marie has a Learning Disability and attends day services and has a respite bed for a week up to three times a year. Mrs. Smith (mother) has mental health issues and has in the past been sectioned; she is currently well and engages with mental health support services. Jamie Smith (brother) is 25; he has alcohol dependency issues and also uses illegal drugs. He refuses to engage with any services
Marie appears very upset at her last day service visit and it becomes clear that she is frightened of Jamie and has injuries that suggest she has been assaulted. She is reluctant to return home at the end of the day

Actions required

Risk assessment – including DASH assessment for both Marie and her mum

Referral to safeguarding for a joint working approach to explore if additional services can be provided to Mum (Mrs. Smith) or Marie and/or support from Jamie

If the risk assessment indicates high-level risk an IDVA should be engaged with the family

Safety of Professionals Working with Domestic Violence and Abuse

Care must be taken to assess any potential risks to professionals, carers or other staff who are involved in providing services to a family where domestic violence and abuse is, or has occurred.

A risk assessment should be undertaken. Professionals should speak with their manager and follow their own agency's guidance for staff safety.

IDVA

IDVAs are Independent Domestic Violence Advisors

IDVAs work in a multi-agency setting, but are independent of all statutory agencies. They provide a range of options to improve the safety of adults and their children as well as empower people to make positive changes. They offer information and support, crisis intervention, safety planning, advocacy and practical and emotional support to enable survivors to make positive changes, reduce risk and minimise the risk of repeat victimisation

http://www.safe-services.org.uk/men/idva-working-with-men.html

Female Genital Mutilation (FGM)

See also **Female Genital Mutilation:** Multi-Agency Practice Guidelines, DH, 2011 **https://www.gov.uk/government/publications/female-genital-mutilation-multi-agency-practice-guidelines**

Introduction

Female genital mutilation (FGM) is a collective term for procedures, which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4 and 13, but in some cases it is performed on young women before marriage or pregnancy.

FGM has been a criminal offence in the U.K. since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and makes it an offence for the first time for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

It is increasingly found in Western Europe and other developed countries primarily among immigrant and refugee communities.

Cultural Sensitivity

Investigating agencies need to be sensitive to the cultural beliefs surrounding FGM and should consult with cultural community groups. However, professionals should not let fears of being branded 'racist' or 'discriminatory' weaken the protection required by girls and women at risk.

FGM is much more common than is generally realised both worldwide and in the U.K. It is deeply embedded in the culture of the practicing community who may resent what they perceive as the imposition of liberal western values on them, but it is not a matter which can be left to personal preference or culture and custom. FGM is an extremely harmful practice that violates the most basic human rights. However, any community education should be sensitive to cultural norms and pressures.

It may be most useful to try to engage community groups and elders or religious leaders in community education programmes. It is extremely important that those running programmes are not seen as alien to the practice. This may create animosity and paranoia within the practicing communities and make it harder to

safeguard adults from FGM. It is important to recognise that children are most at risk of FGM, it is possible that identifying adult women who have been subject to FGM may assist in preventing children being subjected to this procedure

For many families English may not be their preferred language, the assistance of an independent interpreter needs to be considered - see **Interpreting, Signing and Communication Services Procedure**. Any interpreter should be appropriately trained in relation to FGM and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community. This is because girls or women may feel embarrassed to discuss sensitive issues in front of such people and there is a risk that personal information may be passed on to others in their community and place them in danger

The guidance recommends that a female professional be available to speak to if the girl or woman would prefer this.

Raising a concern

If any agency becomes aware of an adult who may have been subjected to or is at risk of FGM they must raise a concern, see **Stage One - Raising a concern/Duty to Enquire Procedure**.

Suspicions may arise in a number of ways that an adult is being prepared for FGM to take place abroad.

All professionals need to consider whether any other indicators exist that FGM may have or has already taken place, for example:

- Preparations are being made to take a long holiday;
- The adult has changed in behaviour after a prolonged absence from home; or
- The adult has health problems, particularly bladder or menstrual problems.

There may be older women in the family who have already had the procedure and this may prompt concern as to the potential risk of harm to other females in the same family.

It should be remembered that this is a one-off act of abuse to a child, although it will have lifelong consequences, and can be highly dangerous at the time of the procedure and directly afterwards and may be part of a controlling or coercive relationship.

Assessment and Case Management

Once a Safeguarding concern has been raised, the case may progress though the safeguarding process.

Family and carers may genuinely believe that it is in the adult's best interest to conform to their prevailing custom. The preferred outcome may be that the family, agree to halt the process. Therefore the main emphasis of work in cases of actual or threatened FGM should be through education and persuasion.

Where an adult appears to be in immediate danger of mutilation, legal advice should be sought, making it clear to the family that they will be breaking the law if they arrange for the adult to have the procedure.

NHS Actions

From April 2014 NHS hospitals will be required to record:

- If a patient has had Female Genital Mutilation;
- If there is a family history of Female Genital Mutilation;
- If a Female Genital Mutilation-related procedure has been carried out on a patient.

From September 2014 all acute hospitals must report this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programmed area of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered Female Genital Mutilation and actively support prevention.

For further information, see Female Genital Mutilation Datasets, Health and Social Care Information Centre (hscic) **http://www.hscic.gov.uk/fgm**

Useful Organisations

Foundation for Women's Health, Research & Development (FORWARD)
http://www.forwarduk.org.uk/
Tel: 020 8960 4000

Black Women's Health and Family Support
82 Russia Lane, London, E2 9LU
Tel: 020 890 3503

Honour Based Violence

Murders in the name of so-called honour, sometimes called ‘honour killings’, are murders in which, predominantly women, are killed for actual or perceived immoral behaviour, which is deemed to have breached the honour code of a family or community, causing shame.

Behaviour that could lead to a murder includes:

- Inappropriate make-up or dress;
- The existence of a boyfriend;
- Rejecting a forced marriage;
- Pregnancy outside of marriage;
- Inter-faith relationships;
- Leaving a spouse or seeking divorce;
- Intimacy in a public place.

These types of murders are often the culmination of a series of events over a period of time and are planned. There tends to be a degree of premeditation, family conspiracy and a belief that the victim deserved to die.

Shame and therefore the risk to the adult may persist long after the incident that brought about dishonour occurred. This means that the victim’s partner (if new), children, associates or their siblings are at risk.

Remember reporting is a brave step and an inappropriate response could put victims, children and other family members at further risk.

Authorities in some countries from which they originate may support this practice and victims may be concerned that you share this view, or that you may return them to their family. They often carry guilt about their rejection of cultural/family expectations. Their immigration status may be dependent on their spouse and it may be used to dissuade them from seeking assistance.

Victims of rape may be perceived by relatives as having brought about the offence and their own family may kill them as a consequence. Women that have fled their marriage are often perceived as bringing shame upon their own blood family. Therefore, they may be at risk not only from their spouses and in-laws, but also from their own father, brothers, sons and wider community, resulting in isolation, depression and, on some occasions, suicide.

Victims are sometimes persuaded to return to their country of origin under false pretenses, when in fact the intention could be to kill them. If a woman is taken abroad, the Foreign and Commonwealth Office may assist in repatriating the woman to the UK.

When dealing with a potential Adult at Risk it is important to recognise the seriousness/immediacy of the risk.

Incidents that may precede a murder include:

- Forced marriage.
- Domestic violence and abuse.
- Attempts to separate or divorce.
- Starting a new relationship.
- Pregnancy.
- Threats to kill or denial of access to children.
- Pressure to go abroad.
- House arrest and excessive restrictions.
- Denial of access to the telephone, Internet, passport and friends.

When dealing with victims, **DO NOT SPEAK WITH THEM IN THE PRESENCE OF THEIR RELATIVES**. Women that return to their families should be offered support including, escape plans, the option to deposit their DNA, finger prints and photograph with the Police. Ensure that you make a full record of what is said, what you have done and to whom you have referred on to.

Where an adult discloses fear of honour-based violence in respect of himself or herself or a family member, professionals in all agencies should:

- Take the disclosure seriously;
- Ensure that the place where s/he is disclosing affords confidentiality;
- Explain the limits of confidentiality;
- Obtain information to make a referral to Adult Safeguarding and the Police;
- Agree a means of discreet future contact;
- Explain that a safeguarding concern to Safeguarding Adults and the Police will be made
- **Professionals should not approach the family or community leaders, share any information with them or attempt any form of mediation**.

All multi-agency discussions should recognise the Police responsibility to initiate and undertake a criminal investigation, as appropriate.

Forced Marriage

- **Forced Marriage of People with Learning Disabilities**http://www.anncrafttrust.org/Forced_Marriage.php
- **Information from the Forced Marriage Unit** http://www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage/
- **HM Government Forced Marriages and Learning Disabilities: Multi-Agency Practice Guidelines** http://www.fco.gov.uk/resources/en/pdf/travel-living-abroad/when-things-go-wrong/fm-disability-guidelines

Introduction
Legal Position

Anyone threatened with forced marriage or forced to marry against their will can apply for a **Forced Marriage Protection Order**. Third parties, such as relatives, friends, voluntary workers and police officers, can also apply for a protection order with the leave of the court. Local authorities can seek a protection order for adults and children without leave of the court. Guidance published by the Ministry of Justice explains how local authorities can apply for protection orders and provides information for other agencies. (This is available at the **Justice website** **http://www.justice.gov.uk/protecting-the-vulnerable/forced-marriage**

The Anti-social Behaviour, Crime and Policing Act 2014 made it a criminal offence, with effect from 16 June 2014, to force someone to marry. This includes:

- Taking someone overseas to force them to marry (whether or not the forced marriage takes place);
- Marrying someone who lacks the **Mental Capacity** to consent to the marriage (whether they're pressured to or not).

Breaching a Forced Marriage Protection Order is also now a criminal offence. The civil remedy of obtaining a Forced Marriage Protection Order through the family courts, as set out above, continues to exist alongside the criminal offence, so victims can choose how they wish to be assisted.

Forcing someone to marry can result in a sentence of up to 7 years in prison.
Disobeying a Forced Marriage Protection Order can result in a sentence of up to 5 years in prison.

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

Forced Marriage and Adults with Learning Disabilities: The Current Issue

The Forced Marriage Unit are experiencing a growing number of referrals involving adults with learning disabilities who potentially lack **Capacity** to consent to a marriage but who have married and are sponsoring the visa for their foreign national spouses to join them in the UK on the basis of this marriage. There are various motivations for forcing people with learning disabilities to marry, some of which include obtaining a carer for the person with learning disabilities or the marriage being seen as the only option for their future. However, the Mental Capacity Act 2005 is clear that there are certain decisions that cannot be made on behalf of another person and this includes the decision to marry. There is

therefore no legal basis on which someone can agree to marriage or sexual relations on behalf of someone who lacks the Capacity to make these decisions independently.

The guidance contained in the multi-agency practice guidelines, Handling cases of forced marriage see **FCO website** http://www.fco.gov.uk/resources/en/pdf/3849543/forced-marriage-guidelines09.pdf recommends that cases involving forced marriage are best dealt with by child protection or 'adult protection' specialists.

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. In this case action will be coordinated with the police and other relevant organisations

Hate Crime

Hate crimes are any crimes (actual criminal offences) that are targeted at a person because of hostility or prejudice towards that person's:

- Disability (The Equality Act 2010 (EA) generally defines a disabled person as someone who has a physical or mental impairment that has a substantial and long - term adverse effect on his or her ability to carry out normal day-to-day activities. The definition of disability hate crime would include anyone who was targeted as a result of his or her disability or impairment, as defined by the EA, including those diagnosed with HIV, cancer and multiple sclerosis);
- Race or ethnicity;
- Religion or belief;
- Sexual orientation;
- Transgender identity.

This can be committed against a person or property.

A victim does not have to be a member of the group at which the hostility is targeted. In fact, anyone could be a victim of a hate crime. Lesbian, gay, bisexual and transgender (LGBT) individuals could face additional concerns around homophobia and gender discrimination. There may be concern that individuals would not be recognised as victims or be believed and taken seriously. Abusers may also control their victims, threatening to 'out' them to friends, family or support agencies.

Hate Incidents

Hate incidents include actions that do not constitute a criminal offence. However such incidents can feel like crimes to those who suffer them and often escalate to crimes or tension in a community. The police can only prosecute when the law is broken but can work with partners to try and prevent any escalation in seriousness.

Hate crime and incidents may involve physical attacks, verbal abuse, domestic abuse, harassment, damage to property, bullying or graffiti.

Mate Crime

Mate Crime is a form of hate crime and is defined as the exploitation, abuse or theft from any person at risk from those they consider to be their friends. Those that commit such abuse or theft are often referred to as 'fake friends'. People with disabilities, particularly those with learning disabilities, are often the targets of this type of crime.

Types of Mate Crime:

- Theft/financial abuse - The abuser might demand or ask to be lent money and then not pay it back. The source of harm might mis-use the property of the adult;
- Physical assault/abuse - The abuser might hurt or injure the adult;
- Harassment or emotional abuse - The abuser might manipulate, mis-lead and make the person feel worthless;
- Sexual assault/abuse - The abuser might harm or take advantage of the person sexually.

A national organisation called Safety Net helps local agencies develop systems to tackle Mate crime. For further information please see the **Arc Safety website** **http://arcuk.org.uk/safetynet/**

For more information on Hate Crime visit the **Government website (Hate Crime)** **https://www.gov.uk/government/policies/reducing-and-preventing-crime--2/supporting-pages/hate-crime**

For more information on Disability Hate Crime and on the way the Crown Prosecution Service (CPS) prosecutes such crime visit the **CPS website (Disability Hate Crime)** **http://www.cps.gov.uk/publications/prosecution/disability.html**

Exploitation by Radicalisers who Promote Violence (Prevent)

The following are part of the UK government's counter terrorist strategy, referred to as CONTEST.

Protecting the UK against Terrorism
https://www.gov.uk/government/policies/protecting-the-uk-against-terrorism

The Prevent Strategy 2011
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417943/Prevent_Duty_Guidance_England_Wales.pdf

The Prevent Strategy: A Guide for Local Partners in England. Stopping people becoming or supporting terrorists and violent extremists
https://www.gov.uk/government/publications/prevent-strategy-2011

Recognising and Responding to Radicalisation: Considerations for Policy and Practice through the Eyes of Street Level Workers
http://www.recora.eu/

The Channel Strategy: Protecting vulnerable people from being drawn into terrorism.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/425189/Channel_Duty_Guidance_April_2015.pdf

Introduction

Radicalisation is defined as the process by which people come to support terrorism and violent extremism and, in some cases, to then participate in terrorist groups.

There is no obvious profile of a person likely to become involved in extremism or a single indicator of when a person might move to adopt violence in support of extremist ideas. The process of radicalisation is different for every individual and can take place over an extended period or within a very short time frame.

Three main areas of concern have been identified for initial attention in developing the awareness and understanding of how to recognise and respond to the increasing threat of people being radicalised:

- Increasing understanding of radicalisation and the various forms it might take, thereby enhancing the skills and abilities to recognise signs and indicators amongst all staff working with adults;

- Identifying a range of interventions – universal, targeted and specialist – and the expertise to apply these proportionately and appropriately;
- Taking appropriate measures to safeguard the wellbeing of adults living with or in direct contact with known extremists.

Understanding and Recognising Risks and Vulnerabilities of Radicalisation

Adults can be drawn into violence or they can be exposed to the messages of extremist groups by many means.

These can include through the influence of family members or friends and/or direct contact with extremist groups and organisations or, increasingly, through the internet. This can put a person at risk of being drawn into criminal activity and has the potential to cause significant harm to themselves and/or the public.

The risk of radicalisation is the product of a number of factors and identifying this risk requires that staff exercise their professional judgement, seeking further advice as necessary. It may be combined with other vulnerabilities or may be the only risk identified.

Potential indicators include:

- Use of inappropriate language;
- Possession of violent extremist literature;
- Behavioural changes;
- Dress codes and tattoos
- Inappropriate use of social media or access to extreme web sites
- Inappropriate behaviour towards some members of the community
- The expression of extremist views;
- Advocating violent actions and means;
- Association with known extremists;
- Seeking to recruit others to an extremist ideology.

Each local area will have a Prevent coordinator who should be contacted to

- Share information
- Assess the risks
- Agree a management plan

Insert local contact details for Prevent coordinators

If there are concerns related to an adult being targeted for radicalisation, the police should be contacted and a concern raised under **Part 2 of the Manual, The Safeguarding Process - Management of Individual Cases**.

Modern Slavery / Human Trafficking

See also **Modern Day Slavery: The Hidden Agenda**
http://www.humantraffickingfoundation.org/sites/default/files/Booklet.pdf
Modern Slavery: How the UK is leading the fight, Home Office
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/328096/Modern_slavery_booklet_v12_WEB__2_.pdf

Human Trafficking, Best Practice Guide, National Crime Agency
http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/best-practice-guide

Modern Slavery encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

Human trafficking is the movement of a person from one place to another, using methods of deception, coercion, the abuse of power or of someone's vulnerability and for the purposes of exploitation. It is possible to be a victim of trafficking even if their consent has been given to being moved. Human trafficking may occur across international borders or take place within one country.

According to the National Crime agency, there are three main elements:

- The movement: recruitment, transportation, transfer, harbouring or receipt of people;
- The control: threat, use of force, coercion, abduction, fraud, deception, abuse of power or vulnerability, or the giving of payments or benefits to a person in control of the victim;
- The purpose: exploitation of a person, which includes prostitution and other sexual exploitation, forced labour, slavery or similar practices, and the removal of organs.

Internet Abuse: Adults Exposed to Abuse through the Digital Media.

Definition

'Internet Abuse' relates to three main areas of sexual abuse:

- Abusive images (although these are not confined to the Internet);
- An adult being groomed for the purpose of sexual abuse;
- Exposure to pornographic or other offensive material via the Internet.

The term digital (data carrying signals carrying electronic or optical pulses) and interactive (a message relates to other previous message/s and the relationship between them) technology covers a range of electronic tools. These are constantly being upgraded and their use has become more widespread through the Internet being available using text, photos and video. The internet can be accessed on mobile phones, laptops, computers, tablets, webcams, cameras and games consoles.

Social networking sites are often used by sources of harm as an easy way to access and target adults who are at risk of abuse.

Internet abuse may also include cyber-bullying. This is when a person is tormented, threatened, harassed, humiliated, embarrassed or otherwise targeted by another person(s) using the Internet or mobile phones. It is possible for one victim to be bullied by many sources of harm.

E Safety is the generic term that refers to raising awareness about how children, young people and adults can protect themselves when using digital technology and in the online environment, and examples of interventions that can reduce the level of risk.

Potential Indicators of Internet Abuse include:

- Spending extended amounts of time online;
- Secrecy over mobile phone and computer;
- Withdrawal from social contact;
- Depression;
- Mood Swings;
- Unexplained gifts;
- Sleep disturbances;
- Self-harming.

Adults who go missing:-

- Adults at Risk who are being sexually exploited may go **missing** from home or care, and education / work. Some go missing frequently; the more often they go missing the more vulnerable they are to being sexually exploited. If an adult does go missing, the **Adults Missing from Hospitals or Care Settings Procedure** should be followed.

- **Independent Return Interviews** with the adult can help in establishing why they went missing and the subsequent support that may be required, as well as preventing repeat incidents. These may be conducted by a social worker, police officer, or other professional known to the adult.

Section 2

Care Act – Section 42 Enquiries Duty.

The Care Act 2014 states, the Local authority must make enquiries or cause others to do so if it believes an adult is experiencing, or is at risk of experiencing abuse or neglect.

The Local authority will decide based on the circumstance of the safeguarding concern which agency is the most appropriate to carry out this function and will make the decision when a case can be closed to the Local Authority where the Section 42 duty is satisfied.

Every reported incident of abuse, or suspected abuse, must be taken seriously and addressed with appropriate urgency by reporting Safeguarding Adult Concerns through to the contact telephone numbers in the table below and the police where a crime is suspected or committed

<table>
<tr><th>BARNSLEY</th><th>SHEFFIELD</th><th>ROTHERHAM</th><th>DONCASTER</th></tr>
<tr><td>Customer Access Team (Members of the Public)
Telephone number
01226 773300</td><td>Adult Access (contact point) telephone number
0114 2734908 (24 hours)</td><td rowspan="3">Assessment Direct
Telephone: 01709 822330

In emergency an situation please call the Police 999 or you have reason to believe a crime has been committed in a non-emergency situation contact the police on 101.
Your concerns will be taken seriously, and we will act promptly and appropriately.
Safeguarding response available until 10pm.</td><td>Adult Contact Team
Telephone number
01302 737391
Deaf Community
SMS Text
07979031116</td></tr>
<tr><td>Professionals seeking advice regarding Safeguarding
Telephone number
01226 775812

Care Quality Commission
03000616161

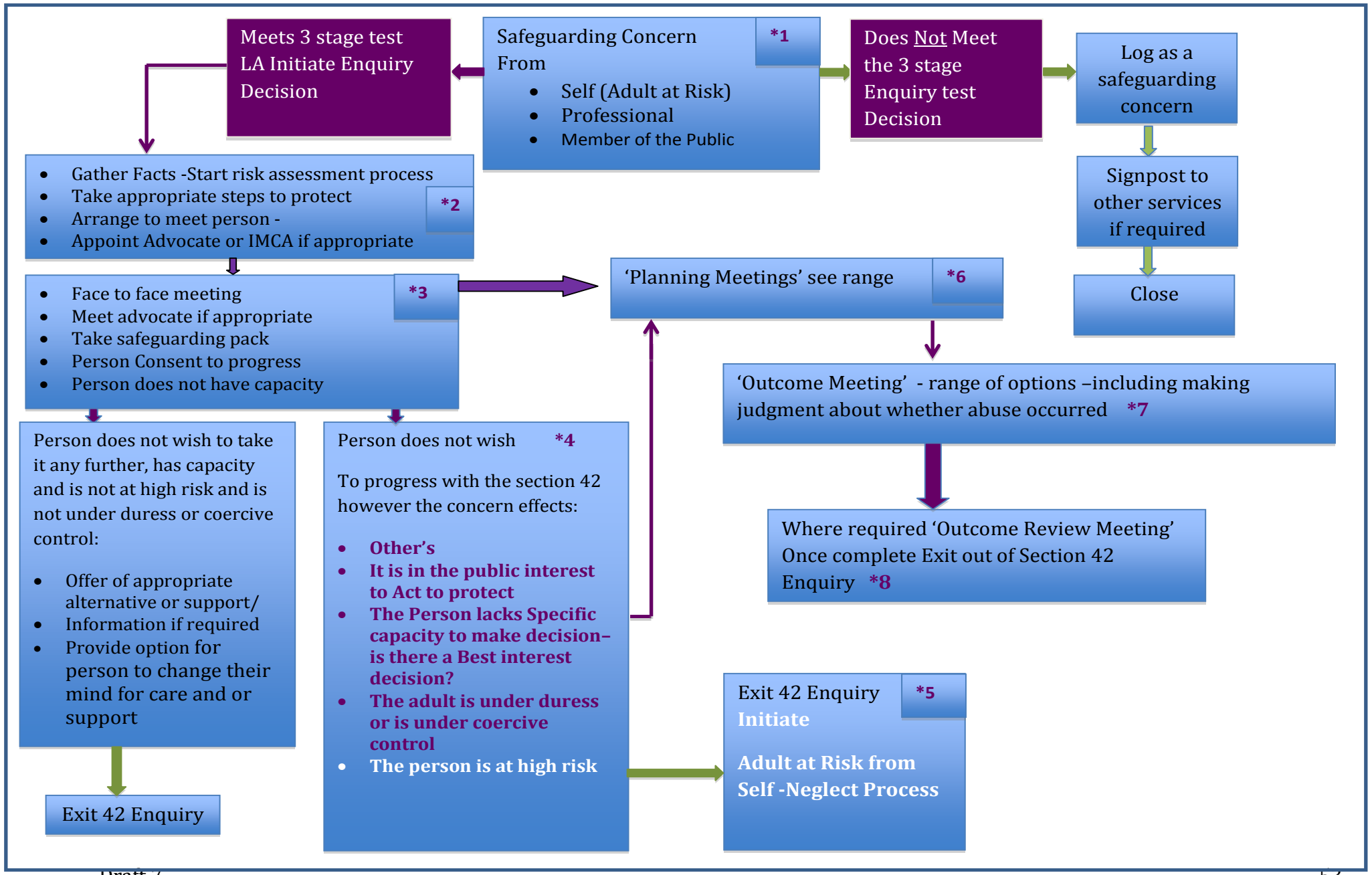
Police

Telephone Contact Number
Non-emergency 101
Emergency 999</td><td>Professional advice line
Monday – Thursday 9.00 – 5.15
Friday – 9.00 – 4.45
Telephone – 0114 2736870

Police Telephone contact numbers
Non-emergency 101
Emergency 999

The Safeguarding Adults Team is open 7 days a week but will only take calls from professionals. For their contact details contact the Safeguarding Adults Office – 0114 2736870.</td><td>Police Telephone contact numbers
Non-emergency 101
Emergency 999</td></tr>
<tr><td>Out of Hours (Emergency Duty Team)
Telephone number
08449841800</td><td>Care Quality Commission
03000616161</td><td>Out of Hours (Emergency Duty Team)
Telephone number
01302 796000</td></tr>
</table>

The following flow chart provides an overview Safeguarding Adult process


Safeguarding Concern From
Self (Adult at Risk)
Professional
Member of the Public
*1
Does Not Meet the 3 stage Enquiry test Decision
Log as a safeguarding concern
Signpost to other services if required
Close
Meets 3 stage test LA Initiate Enquiry Decision
Gather Facts -Start risk assessment process
Take appropriate steps to protect
Arrange to meet person -
Appoint Advocate or IMCA if appropriate
*2
Face to face meeting
Meet advocate if appropriate
Take safeguarding pack
Person Consent to progress
Person does not have capacity
*3
'Planning Meetings' see range
*6
'Outcome Meeting' - range of options –including making judgment about whether abuse occurred *7
Where required 'Outcome Review Meeting' Once complete Exit out of Section 42 Enquiry *8
Person does not wish to take it any further, has capacity and is not at high risk and is not under duress or coercive control:
Offer of appropriate alternative or support/
Information if required
Provide option for person to change their mind for care and or support
Exit 42 Enquiry
Person does not wish *4
To progress with the section 42 however the concern effects:
Other's
It is in the public interest to Act to protect
The Person lacks Specific capacity to make decision– is there a Best interest decision?
The adult is under duress or is under coercive control
The person is at high risk
Exit 42 Enquiry Initiate
*5
Adult at Risk from Self -Neglect Process

Overview of Timescales within the Safeguarding Process

The following timescales are set within good practice guidance and each case should be risk assessed and the timescale directly linked to assessed risk or the circumstances affecting the individuals ability to be involved (for example critically ill/awaiting advocacy etc.)

Safeguarding Concern	Stage *1 &*2	**24 – (72 hours** where this occurs at a weekend or bank holiday.) On receipt of the concern, a decision will be made as to whether this is a Section 42 Enquiry or not	
Enquiry Commenced if the adult meets the S42 three stage test			Rolling days
Face to Face Meeting	Stage *3 *4 & *5	Within a maximum period of **15 working days** (3 weeks). This will be dependent on the Adult at Risk advocate or other support required. If the adult lacks capacity an IMCA should be appointed During the face -to -face meeting where there is a single agency involvement, it may be appropriate that the discussions about desired outcomes and planning actions take place with the enquirer (representing that organisation) and Adult at Risk.	21

Decision Making/Planning Meeting		If not agreed within the above Face to Face meeting To be completed within maximum period of **2 weeks** from the date of the face-to-face meeting.	35
Enquiry Completed	Stage *6	To be completed within 6 weeks from the date of the Decision Making/Planning meeting	77
Outcome Meeting	Stage *7	Within **23 weeks** of the Section 42 enquiry commencing	147
Review outcome meeting	Stage *8	No longer than **10 weeks from first outcome meeting but can be earlier if the risk is significant**	

Roles and Responsibilities

Stage	Current Roles	New /potential Roles
Concern	Anyone can raise a concern, where a worker is raising a concern it is expected that this will be made on the same working day	Same as current role For local details of how to raise a concern see below
Screening for a S42 enquiry (the Local Authority receives the concern)	Local Authority, Commissioned mental health services	Local Authority,
Causing others to make an enquiry	N/A	Health professionals in both primary and secondary care, Housing, police
Face to Face	Social worker, housing support worker, health	Any worker who has received relevant training

	workers, police, GP etc.	– see local links
Decision Making/Planning meeting	Chaired by Local Authority Safeguarding managers, mental health safeguarding managers, health safeguarding managers	Any worker who has received relevant training
Section 42 Enquiry assurance		As the Local Authority retains the responsibility for enquiry's, it must ensure the enquiry satisfies its duty under section 42 Local Quality assurance challenge processes once established, will be applied at each stage of exit and or following an outcome meetings. Each LA area are working up this process within the SAB arrangements
Outcome meetings	If the outcome meeting is making a decision on organisational abuse, this will be chaired by an independent chair If the outcome meeting is a family group conference or other format this may involve a safeguarding manager but may involve senior representatives from agencies involved in the enquiry	As local and regional work continues to develop our response to Making Safeguarding Personal (MSP) the range of outcome meetings and agencies role in these will be agreed to reflect the new structures Currently the options are provided within this section of the procedures, A review these procedures will take place on a 6 monthly – basis where further developments will be reflected.
Review outcome meetings		

Step 1

Safeguarding Concern *1
Is received from

- Self (Adult at Risk)
- Professional
- Member of the Public

Safeguarding concerns should be shared as soon as possible. Workers must share concern in the same working day

A Safeguarding concern is received into the local authority and recorded onto a Local Authority Safeguarding Adult Concern Form (**SACF1**) the information received is then considered against:-

What do we mean by a Concern?

A concern may result from a disclosure from the adult, evidence from a visit/conversation or a feeling of anxiety or worry that an adult is unable to protect themselves from either the risk of, or the experience of abuse or neglect. Sharing your concern is telling someone that you are aware or suspect that abuse has taken place. Everyone who works with an Adult at Risk has a duty to share their concerns, even if the Adult at Risk asks them not to. It is always good practice to inform the Adult at Risk of this duty, unless it may put the individual or other adults or children at risk.
Anyone can raise a Concern, for example:

The Adult at Risk.
A paid or informal Carer.
A volunteer.
A General Practitioner.
A member of the public.
A police officer.
Fire service staff.
Council staff.
Health service staff.
Department of Work and Pensions staff.

****This is not an exhaustive list****

What to do if you Suspect Abuse

Ensure Safety

The first priority is to ensure the safety and protection of the Adult/s at Risk. In making the person (and others potentially at risk) safe, it may be necessary to report the concern to the police (if a crime has been committed or to prevent a potential crime) or the emergency services as required. It may be necessary to organise an assessment for medical treatment, contact organisations providing services or organisations that may need to provide an emergency assessment of needs. Practical support such as the landlord replacing broken windows etc. may be required. If medical treatment is not immediately required, medical triage may be arranged following discussions with your Manager (see Local Contacts).

If the source of harm is a paid member of staff/volunteer, then consideration should be given by their employer to suspension of these individuals pending an investigation, under HR processes.

Foreign National Adults at Risk including victims of trafficking who go missing will be reported directly to the police and the Local Authority they are associated with, please see local guidance.

When an Adult at Risk goes missing or is found they will receive a multi-agency safeguarding response, please see local guidance.

Home Office Document, Missing Children and Adults: A Cross Government Strategy.

Please ensure a discussion with the Adult at Risk takes place regarding their wishes and feeling in respect of the desired outcome of the enquiry after the initial screening and risk assessment

Preserve Evidence

Where it is suspected that a crime has been committed, the police should be contacted immediately and physical, forensic and other evidence should be preserved, see Achieving Best Evidence: Witness Support and Special Measures.

Preserving forensic evidence includes:

Disturbing a ‘scene’ as little as possible, sealing off areas if possible.
Not removing the clothing of the adult subjected to the alleged abuse.
Discouraging washing/bathing.
Not handling items, which may hold DNA evidence.
Removing any bedding, clothing /putting any bedding, clothing which has been removed, or any significant items given to you (weapons etc.) in a safe dry place.

Securing phones / laptops that may contain evidence of communication between the adult and the alleged source of harm.

Other evidence can be obtained, or preserved by:

Accurate recording of any disclosure using the persons words
Not interviewing the adult subjected to the alleged abuse without agreement from the Police
Not interviewing any potential witnesses
Not alerting the person associated with the alleged source of harm
Making a note of your observations in relation to any environmental factors and or context of the situation and the attitude of the people involved and any actions you have taken
If the adult subject to the alleged abuse is already receiving services via care/case management or Care Programme Approach routes, this should not preclude a Safeguarding Adults Concern where a concern is raised or abuse is disclosed

Report and Record

The organisation you work for should have an internal safeguarding protocol with specific guidance on where or whom you should inform about potential abuse. If you are unsure who to share information with, inform your line manager. If your line manager is not available, you will need immediately to contact your Local Authority Adult team (see local contacts) or the police if you suspect a crime has been committed.

The concern must be reported immediately – See Page 75.

If you suspect that the person/manager you would normally pass any concerns to may be a the source of harm or involved in some way, you will need to seek advice immediately from another manager or, your local Safeguarding Adults Office, or if out of hours, the out of hours service or the police (See page 76)..
(See section on ‘Allegations against Staff, Managers, Carer’s or Service Users’).
Records of incidents and concerns should be written as soon as possible, with the date, your signature and designation made clear. If records are hand-written, the original should be kept for evidential purposes.

Workers should be aware that their records relating to any concern or enquiry could be used as evidence in a range of procedures: disciplinary, criminal or at a safeguarding outcome meeting.

Good Practice for raising a Concern

When you become aware of abuse or neglect, you should make sure that emergency assistance, where required, is summoned and that your concerns are reported to your manager within your own organisation immediately;
Any information given directly by the adult concerned should be listened to and recorded carefully, using the person’s own words;

Only clarify the bare facts of the reported abuse or grounds for suspicion, do not ask leading questions e.g. suggesting names of who may have perpetrated abuse if the person does not disclose it.

If an Adult at Risk makes an allegation to you asking that you keep it confidential, you should inform the person that you will respect their right to confidentiality as far as you are able to, but, that you are not able to keep the matter secret;
Do not take any actions, which might alert the source of harm.
Record all factual evidence accurately and clearly in line with your organisation's requirements and policies.
Never prevent or dissuade another person from raising concerns, suspicions or presenting evidence.
Do not discuss the incident with anyone without agreeing this with your line manager.

Gathering Information from the Person Raising the concern

In accordance with National Reporting Requirements, the information Supplied should be gathered and shared as a minimum.
See safeguarding Concern Form SACF1

A lack of access to the necessary information should not delay the concern being reported.
A safeguarding concern becomes an enquiry when the details lead to a decision that the adult meets the Care Act definition and a Section 42 Safeguarding Enquiry is required

Checklists for Concerns

These are checklists to aid decision-making. Procedures should be referred to at all times and professional judgment should be applied throughout.

Checklist 1

Ensure the immediate safety of the Adult at Risk.
Seek any immediate medical attention where required.
Complete body map (see Body Maps Procedure) where appropriate.
Has a crime or a potential crime been committed? If so you must report this to the police unless the Adult at Risk is assessed to have capacity and is clearly saying they don't want any action taken. This information will be shared later with the police as part of the Local Authority's screening process .
Preserve any evidence.
Record accurately any information provided by the adult, their family etc. (using their own words)
Do not alert the alleged source of harm.
Is the Adult at Risk safe now?

Does anything more need to be done? To protect other adults or children? If so notify the children's safeguarding or other access route for children's
If the adult has disclosed what do they want (outcome) If so please record this
Are there any grounds to doubt their capacity to make this decision (MCA or coercive control)

If the safeguarding concern meets this test

The safeguarding duties apply to an adult who:

1. Has needs for care and support (whether or not the local authority is meeting any of those needs)

2. Is experiencing, or at risk of, abuse or neglect

3. As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

This is automatically made into a Safeguarding Enquiry and moves on to stage 2 of the process

Meets 3 stage test
LA Make initiate Enquiry
Decision and retain or 'cause others to undertake the Enquiry

If the safeguarding concern does not meet the 3 Stage test, the reasons for this decision and any offer of additional service, advice or guidance given, **must be** recorded on the **SACF1**

Having made the Enquiry decision the Local authority will then consider who is best placed 'to cause the enquiry'

You or your agency may be the most appropriate person to undertake the enquiry based on your involvement with the Adult at Risk and or the relationship you have with the individual

Please note

At this point of the procedure development this function will only be applicable to

health e.g. Clinical Commissioning Group, NHS England, Foundation Trusts, further updates on the procedures will capture other agencies as they come on line with specific training and governance arrangements to capture the roles and responsibilities of this function.

The following agencies where this will be applicable in the near future will be the Local Authority Domestic abuse service; Housing and the independent care homes and hospital sector.

Step 2

- Gather Facts -Start risk assessment process *2
- Take appropriate steps to protect
- Arrange to meet adult (at risk)
- Appoint Care Act Advocate or IMCA if appropriate

Gather Facts

This process includes gathering information from systems held within the Local authority and in conversations held with other professionals including GP's and the police where appropriate, who know, or have some involvement with the Adult at Risk.

Start Risk assessment process

Risk Management

An initial risk screening will have been commenced, as part of screening the concern consideration will have been given to –

- ✓ Level of threat to the person at risk's physical or mental well-being
- ✓ The nature/extent of the abusive acts
- ✓ Whether the abuse was a one off event or part of a long standing relationship or pattern
- ✓ The impact of the abuse on the adult and their independence
- ✓ The intent of the alleged source of harm – Is this a potential hate/mate crime
- ✓ The risk of the abuse being repeated to the Adult at Risk, other adults or children. (Consider a risk assessment and referral to services if appropriate) (risk to other adults may result in an enquiry without the consent of the adult)
- ✓ The risk that harm would result or impact of harm escalate if no action was taken

- ✓ The incident involves a regulated service provider (inform Care Quality Commission and Contracts) (in these cases we may progress the enquiry without the consent of the adult)
- ✓ The concern involves a commissioned service not regulated by CQC
- ✓ Do the allegations involve “persons in position of trust” (workers or volunteers) (we may progress an enquiry without the consent of the adult)
- ✓ A crime has been committed

Ideally in advance of the face to face meeting you will need to have answered all of these questions to support a realistic discussion with the adult about their perception of the risks and consequences and based on the information shared that you may be required to go against their wishes and give the reasons to them WHY you need to take this action. (I.e. public interest, others at risk)

You will need to record any evidence as to why you have not been able to access relevant information in advance of the meeting if you are not able to do so and if an agency/organisations is or remains unwilling to share information please notify the Safeguarding Adults Office – see local contact details for information

In advance of the meeting with the Adult at Risk the worker(s) will need to balance this information in context to produce a proportionate and balanced approach to the risk(s)

Some of the areas that it would be helpful to consider include -

- ✓ Capacity of the adult – always start with a presumption of capacity – however it is essential to consider the impact of coercion/control (domestic violence) and duress – Mental Capacity Act
- ✓ Their current, or if they now lack capacity (previous), their views on the risks in their lives. When you meet with then this may change
- ✓ The risks in context – of family member i.e. taking £30 per week may not result in any harm and the adult may be willing to pay this to guarantee contact with the family. Even if the loss of money is resulting in harm, the adult still may be willing to support family continuing to have access to the money to maintain an otherwise positive relationship
- ✓ Has the adult a long history of abusive relationships (low self-esteem/self-worth), their perception of risk/abuse is very different from other adults
- ✓ Has the adult a negative history on contact with statutory services – will this reduce the chances of them accessing support and help
- ✓ Are they able to demonstrate that they can and will protect themselves if the situation continues to deteriorate
- ✓ Has the adult any positive influences in their life – family, friends, organisations who can support the adult to reduce or remove the risks
- ✓ Has the adult got the necessary information/skills to access help or to remove themselves from the source of harm

- ✓ Have they a history of agreeing to action and then being unable or unwilling to deliver on these commitments

Mapping these out under each broad risk area will assist your conversation with the adult, their family or advocate/IMCA and support you in rating the risks as high, medium or low

Risk	History	Context
Financial abuse	Long history of abuse by family – physical, psychological and financial Negative history of contact with the police – been involved in ASB as the source of harm Negative relationship with social care in the past – parenting issues Added to income by taking on "bits of work"	Concerns about fluctuating capacity? Early onset dementia? Change in behaviour? No positive influences in the family – "norm" to take money from the adult Limited access to external support – unsure if this would be accepted Unable to supplement income and living expenses increased due to increased heating bills etc. Increased number of adults – children and grandchildren now taking money from adult
(At the face to face meeting you will need to review your judgment on risk, based on the conversation with the Adult at Risk)		

The risk should be reviewed regularly throughout the section 42 enquiry and recorded on the relevant SA forms

Immediate Actions

The first priority is to ensure the safety and protection of Adult at Risk. In making the person (and others potentially at risk) safe, if a crime has been committed it must be reported to the police or if the person is injured it may be necessary to seek emergency services. If medical treatment is not immediately required, medical examinations should be arranged where appropriate.

The use of Independent Care Act Advocate – Section 68 - Care Act 2014

Independent Care Act Advocates - guidance
The Local authority must arrange an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care and support plan and in the review of their care plan, as well **as in safeguarding enquiries and SARs** if two conditions are met.

That if an independent advocate were not provided then the person would have: -

(1) Substantial difficulty in being fully involved in these processes and second,

(2) There is no appropriate individual available to support and represent the person's wishes, who is not paid or professionally engaged in providing care or treatment to the person or their carer.

The role of the independent advocate is to support and represent the person and to facilitate their involvement in the key processes and interactions with the local authority and other organisations as required for the safeguarding enquiry or SAR.

The nature of safeguarding concerns is likely to mean that adults who would ordinarily be able to engage in assessments may struggle to engage with safeguarding due to distress, embarrassment, fear etc. It is essential that assumptions are not made about adults who previously had little difficulty in engaging with assessments when receiving and responding to a safeguarding concern.

This Duty to involve an advocate applies in all settings including people living in the community; this duty does not include prisons.

See Appendix 2: for Judging 'substantial difficulty' in being involved

Other Factors to consider

Did the adult require support from family/friend to engage with assessment for services etc.?

- Does the alleged source of harm have a close relationship with the adult or is the alleged source of harm the person who would have assisted with assessments?
- Will the section 42 Enquiry involve contact with agencies the adult has not previously had contact with (police, courts, etc.) Would the family/friends supporting the person be likely to encourage very risk adverse solutions

In all of these (and potentially other examples) an advocate **should be offered** to the adult, including information about the role of the advocate in the safeguarding process

Please Note

Some individuals will already have appointed advocates involved in supporting them, where this applies you must ensure that the advocate is informed and involved wherever this is applicable, in order for them to provide the wishes and views of the Adult at Risk throughout this process.

The Role of Independent Mental Capacity Advocates (IMCA) in Safeguarding (ADASS Guidance)

In line with ADASS guidance an IMCA **should always be appointed for an adult who lacks capacity unless it will bring no additional benefits.**

Examples
For adults who are subject to harm from family members/friends an IMCA should always be appointed at the start of the safeguarding process
For adults who have supportive families/friends but who may be "risk adverse" i.e. would push for a 24 hour care solution an IMCA should be appointed to avoid a potentially unlawful deprivation of liberty

For adults who have supportive families/friends who will support the adult in line with their wishes and the appointment of an IMCA may result in distress to the adult, it would be appropriate not to appoint as it will bring "no benefits".

Step 3

- Face to face meeting *3
- Meet advocate if appropriate
- Take safeguarding pack
- Person agrees to progress
- Person does not have specific capacity to progress

Face to face meeting

The face-to-face meeting is one of the significant changes to the safeguarding process within the Care Act and introduces fundamental changes to the way in which professional and Adults at Risk work together.
The guidance in this section provides practical steps for professionals undertaking this process.

Note
If the person is known not to have specific capacity to be involved in the safeguarding process then proceed directly to **step 6**

If it is unclear that the person has specific capacity at the point of the safeguarding concern, during the face-to-face visit, a capacity assessment will be

required. This will then require a prompt best interest decision meeting to take place.

If the outcome is the person lacks specific capacity, proceed to step 6.

If the result is that the Adult at Risk does have capacity then proceed with the face-to-face interview.

Making Safeguarding Personal Practitioner's Guidance Notes

Introduction

Making Safeguarding Personal is a Local Government Association Initiative, which looks at outcomes for Adults at Risk who are subject to a safeguarding Enquiry.

The aim of this guidance is to assist practitioners to focus on the following;

- engage people throughout the process with a focus on outcomes for the Adult at Risk
- making people feel safe
- making people feel empowered and in control
- an asset based approach to help identify individuals strengths and networks

Principles

1: Building a trusting relationship

The first meeting with someone who has reported being abused is crucial. They may have spent many months, even years, plucking up the courage to disclose what happened to them. They may have conflicting feelings - 'I still love the source of harm', 'Am I doing the right thing?', 'Will anyone believe me?'

They may have conflicting fears - 'Will the source of harm take revenge?' 'Will I get into trouble?' 'Will I have to leave my home?'
So the first thing to do is reassure them. Although you will not be able to offer complete reassurance about everything, there are areas where you can.
For example, you should acknowledge the impact the abuse has had on their life; make clear that you take them seriously; tell them it is natural to have conflicting feelings and fears; and say that protection is available. Remain calm and do not show shock; however always take an empathic approach - you are a human being too and not a robot.

2: Helping people to disclose

Only after establishing this initial acceptance and starting to build trust can you go on and ask for evidence - in a person-centered approach you may have to switch between stages many times as the disclosure of evidence is both therapeutic and cathartic.

You must use the person's own language and constantly check your understanding; don't assume what they think or feel. When you record what they have said, continue to write it in their own words.

Only report what they say, not what you think they mean. The person's account, and your record of it, is important evidence and can make the difference between a successful or negative outcome for them.

Stage 3: Establishing what the person wants

When people disclose that they have been abused they usually want something done about it. It is important to find out what that is and not make any assumptions of what you think they need.
Sometimes they may have a very clear view but often they have not thought that far ahead nor have a number of outcomes in mind, not all of which are compatible or even possible.

Do not leap ahead and immediately discount the unrealistic outcomes, but listen and note. Only then can you begin the task of helping them look towards their future and planning what can happen. Their views on outcomes may change throughout the process.

Stage 4: Personal centered risk management

It is natural that you will want to make the person as safe as soon as possible, but safety is relative.

People often want to be both safe and to maintain unsafe relationships.

There is an important distinction between putting people at risk and enabling them to choose to take reasonable risks. The emphasis must be on sensible risk appraisal, not risk avoidance.

Always look for the least restrictive option and go through the alternatives with the person.
You may need the support of the multi-agency team to analyse the risks and to manage them in a balanced way.
Always appraise the risks with the person and take them through the consequences of the options so that they actively develop their own risk management plan.

Stage 5: Putting the person in control

You can never promise complete confidentiality in abuse cases nor can you totally predict outcomes, but you can put the person at the center of the whole process by giving them as much control of the decision-making as possible.

They may have had power stripped away from them, but you can support them to rebuild their confidence and power over their own life. This can be achieved by explaining what the options are, the extent of your own powers and those of the police, the legal protections and procedures and how they can seek justice.

While you will have your own ideas (and those of other professionals) on how the case should progress, it is important that you share them with the person and build the safeguarding plan around what they want. Where it is not possible to do this then you must explain why but re-emphasise what is within their control.

Stage 6: Finding the right time to end

The safeguarding process will usually finish at the point when the person's outcomes are achieved. However they may only be partially achieved or some not even reached at all, so when does the process stop? Quite simply it should be when the person says that they now feel safe and are confident that they will continue to feel safe.

- If you have worked in a person-centered way then the conclusion will come quite naturally.
- You will then need to re-evaluate with the person the levels of risk that remain and how they will deal with them.
- You should leave them with knowledge of their support system and what to do if they feel at risk again.
- Some will require a regular review if the risk of harm remains high.

A tool kit

A tool kit has been devised to help capture the Adult at Risk views and perspective and will assist in working with the Adult at Risk to identify their concerns, clarifying the risk, consider the consequences and options open to them to support then in feeling safe. (See Appendix 2)

Planning the face to face meeting with the adult

- Complete a pre meeting risk assessment (if Domestic Abuse is identified complete a DASH assessment) and agree this with your manager
- Established who should be involved in the initial meeting – you may not be the most appropriate person /agency. If not have you discussed and agreed with the most appropriate person if they are able or willing to take on this responsibility?

- Establish where the meeting will take place – balancing the need for confidentiality with the person feeling comfortable, if possible see the person alone unless there is an Advocate or IMCA involved in which case a joint meeting should be arranged
- Have you confirmed that the person has capacity and does not need an IMCA?
- If the person has capacity do they need an IMCA as the risk comes from family?
- Do they need an advocate as they will struggle to engage with an outcome conversation without support and have no family or significant others to assist with this? (See Appendix 3)
- Has the individual got any communication needs – translator, signer, speech board etc.? If so do you need advice from a specialist to assist with the planning of the meeting/discussion and what impact might this have on how you record the conversation?
- How are you planning to record the conversation?
- Have you a "script" to explain to the person who you are and what safeguarding is all about? (See Appendix 4)
- Have you a leaflet/information sheet you can leave with the person with contact details?

Prior to your visit you must have due regard to:

(a) The importance of beginning with the assumption that the adult is best-placed to judge their own well-being

(b) The adult's views, wishes, feelings and beliefs

(c) The importance of preventing or delaying the development of needs for care and or support and the importance of reducing needs that may already exist

(d) the need to ensure that decisions about an adult are made having regard to all of their circumstances and are not only based on age, appearance, condition or behaviour which might lead others to make unjustified assumptions about the adult's well-being

(e) The importance of the adult participating as fully as possible in decisions and being provided with the information and support to enable this to happen

(f) Achieving a balance between the adult's well-being and that of their representative, involved in care

(g) The need to protect people from abuse and neglect

(h) The need to ensure that any restriction on the adult's rights or freedom is kept to the minimum

At the face to face meeting

- Explain the purpose of the meeting and confirm that the adult is willing to discuss the safeguarding concern and what they would like as an outcome(s)
- Ask the person to explain in their own words what they feel the risks and consequences are to their safety and what they feel would help them reduce them (e.g. supportive family, friends, faith groups, changes to financial management etc.)
- If the person does not address all the areas identified in the risk assessment, explain the additional areas of concern and ask them for their views about the accuracy / relevance and consequences/impact of these risks to them and how they propose to reduce or manage these risks
- Ask the person to outline what help agencies can give them to make them feel safer both short and longer term. For each topic spend some time teasing out what exactly they would like and giving feedback as to whether or not these are realistic outcomes. (e.g. – would like to win lottery and move to Spain – this is unlikely to happen).
- Explain that in some cases we will need to take action as other adults may be at risk and give them the option to be updated as the section 42 enquiry progresses
- Agree a set of outcomes
- Agree with the adult what their role and the role and responsibilities of others involved in the enquiry will be?
- Complete a sheet with key outcomes listed on it and a list of contact names and numbers See example on page 124-128
- If active risks remain explore and if possible agree with the adult the actions that they or a family or other family members/friends can take to reduce these and which agencies will be able to help if they are contacted
- Provide a list of contact details for relevant organisations this should be left with the individual, including a timetable for contact with the person by you as the named worker

Recording the face to face meeting – Template to follow

Stage 4

Person does not wish *4
To progress with Section 42 enquiry however the concern effects:

- **Other's**
- **is in the public interest to Act to protect**
- **The Person lacks Specific capacity to make decision–is there a Best interest decision?**
- **The adult is under duress or is under coercive control**
- **The person is at high risk**

Exit 42 Enquiry

Initiate
Adult at Risk from Self -Neglect Process
If Domestic Abuse – DASH assessment completed and check if a joint response with Safeguarding is required

Are others at risk?

Consider whether others may be at risk based on the circumstances of the concern and or the environment the Adult lives in

It is in the public interest to Act to protect

'Anything affecting the rights, health, or finances of the public at large'

Public interest is a common concern among citizens in the management of local, state, and national Government.
A public utility is regulated in the public interest because private individuals rely on such a company for vital services.

Safeguarding Pack

The following tool kit and leaflet will support the discussions needed as part of the face-to-face meeting
Leaflet - Agreement of contact and support throughout process See appendix 3

Toolkit (for debate/discussion)

1) Mapping tool.
   The purpose of this tool is to support the adult to identify the people and networks that are important to them/relationships they are involved with

and whether these individuals/networks are an asset /and provide help in enabling risk risks to be managed,

Mapping relationships allows the person to take control of the risks in their lives by engaging people/relationships/networks that will be able to assist them to stay safe; it will also provide an opportunity to identify any individuals within their current networks who may be a risk (even if they are not currently identified as the alleged source of harm)

Family	**Friends and non paid relationships**
Paid support	Networks

For each area of concern identified and record what the adult feels is working, this may contribute to reducing the risks linked to this concern – is also it possible that the risks may increase depending on the information shared

What is NOT working – Explore with the Adult at Risk what may be possible to reduce these areas to improve safety

This model will pull out any tensions/conflicts/inconsistencies and strengths in managing risk and any issues not identified in the relationship mapping allowing the Adult at Risk and the worker to focus in on the impact on the following people

The adult
Family and friends
Networks/community
Other – including organisations

For each concern/risk identified and using any information gathered from use of the previous information examine the following – it may be possible to prepopulate this in advance of the visit and consider if easy read or other information can be provided to support the adult's involvement in the discussion (especially around the law)

Who	Impact – current and possible	What is the impact of not supporting th adult to take risks – lost opportunities	Is there a legal view on this – Mental Capacity Act/Human Rights

			Act/ etc.
Adult			
Family/friends			
Networks/community			
Other – identify who			

From this it may be possible to agree a list of options/actions and which are acceptable to the Adult at Risk

For each risk list all the possible outcomes with the adult and/or their family/friend/advocate - then agree with the adult if they are

- ✓ Keen to try this
- ✓ May be willing to try this
- ✓ Not willing to try this

Getting the adult to explore their reasons for the decision would be helpful

From this a “shopping list” of tasks can be agreed detailing

- ✓ Who will do
- ✓ What they will do
- ✓ When
- ✓ How they will communicate back to the adult on their progress
- ✓ What they will do if the option is not available following the discussion

Finally it is important to support the adult to retain control about decisions in their lives (unless they chose to delegate them) or feel that they are not important to them and they want to “opt out” of these decisions

It may be that some decisions they will NOT be able to have control over as there may be risks to other adults etc. which may mean actions and decisions will need to be taken without their consent (they should be informed unless doing so places other Adults at Risk)

Adults should be supported to

- ✓ Identify the decisions that are important to them relating to the S42 enquiry
- ✓ Identify how they will be involved
- ✓ Identify which decisions will be outside of their control and why and what information they can be given and at what stage

As a practitioner at this point

- **The Adult at Risk should be clear on what outcomes and support they would like to achieve. Agreement between the adult and practitioner should be reached on how best this can be delivered.**

Or

- **The Adult at Risk does not wish to pursue any further within the Enquiry process, and <u>does meet</u> one or more of the concerns in stage *4 of the process. Proceed with enquiry**

Adults at risk from self -neglect

Defining self-neglect

The challenge of defining self-neglect has proved a barrier in the development of policies and procedures and so moving towards a national definition of self-neglect might be helpful.

Previous research on self-neglect (Braye et al, 2011) was used as the basis for exploring the parameters of policy and practice in the present study and, for definitional purposes, self-neglect in the study includes adults both with and without capacity, and centers on:

- lack of self-care – neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing, and/or
- lack of care of one's environment – squalor and hoarding, and/or
- Refusal of services that would mitigate risk of harm.

However, as people who use services and practitioners observed in this research project, there is no typical self-neglect case.

Stark contrasts emerge between those neglecting themselves and those neglecting their home environments, and between different types of, and reasons for, hoarding.

Self-neglect may be a longstanding pattern or a recent change and be linked to loss, past trauma and/or low self-esteem.

People may be at risk from other people and their responses shaped by rationalisation, shame or denial.

Professional interest in an individual's self-neglect, triggered by the level of harm or risk associated with the behaviour may be at odds with the individual's own perception of the behaviour.

Flexibility of response, informed by an understanding of each unique case, is one key ingredient of effective practice.

Please note adults identified at risk of self-neglect may also be experiencing or at risk, from individuals who may target adults, resulting in abuse. These cases are not grounds to exit a Section 42 Enquiry.

The Care Act requires examination of the impact of self-neglect by adults; in South Yorkshire this will be managed locally but will only apply to adults in the following circumstances

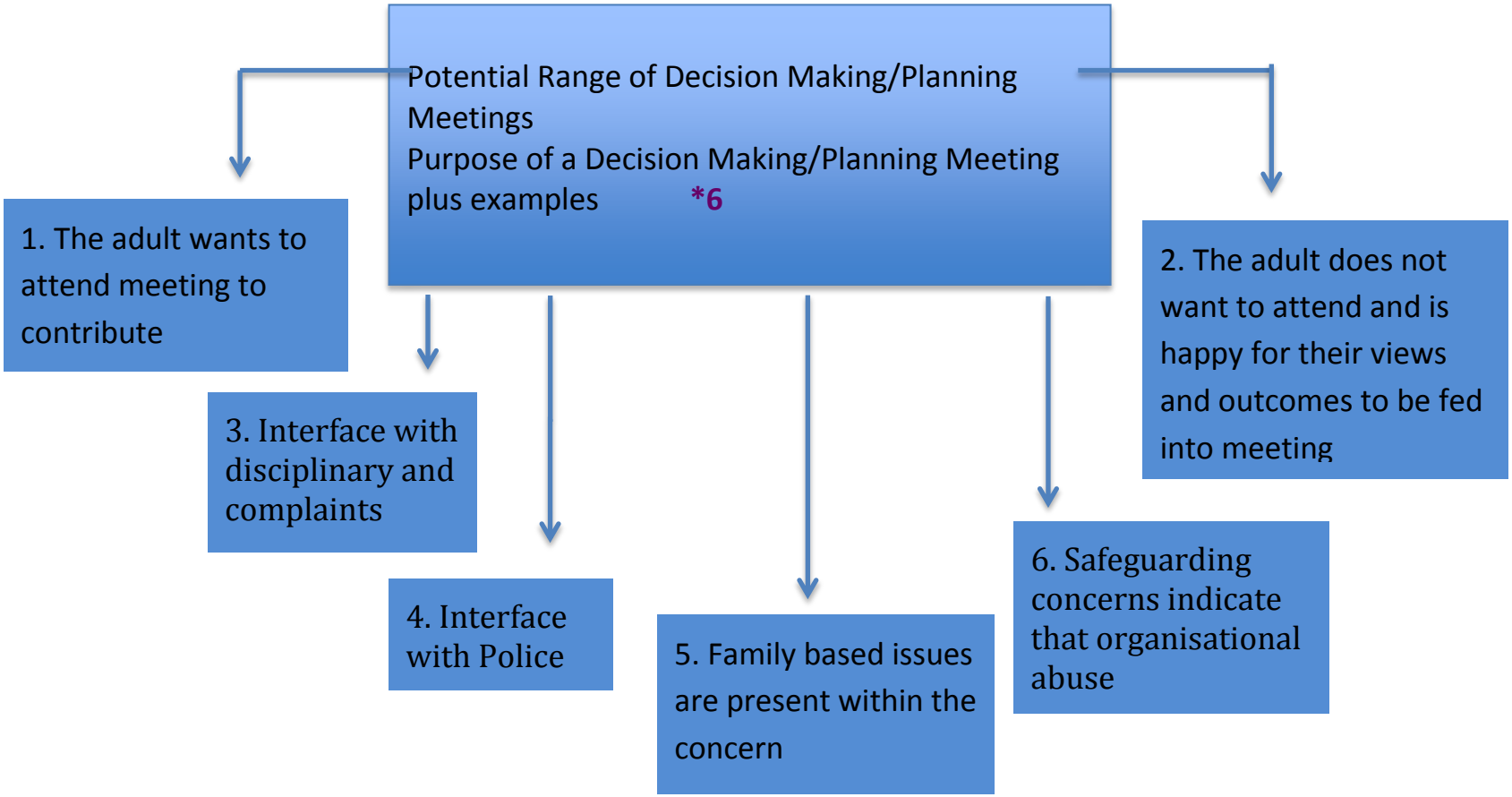
- Have capacity to make the decision(s) causing concern
- The self-neglect is not a response to abuse by another person
- Results in risk(s)/harm to the individual

It is essential that capacity is kept under review for all adults managed within the self neglect processes, especially for adults who regularly misuse alcohol or drugs.

Each South Yorkshire area is developing or has their own defined policy in dealing with this subject (previously Known as VARMM)

Step 6

Planning Meetings Options



Police Role in Meetings

As a Safeguarding Manager, prior to holding any discussions or attending meetings, it is important that a discussion with the police takes place where there is a crime or a suspected crime.

The main reasons for this are to:-

- Seek the progress of the police investigation.
- Establish what information the police can or cannot share within the meeting.
- If information is to be shared confirm who with.
- Establish what progress can be made with the enquiry whilst the criminal element is being investigated.
- Be clear with the police on your intended actions so that any conflict can be identified.

Can I continue progress with the enquiry if the police are involved?

If all of the above points are addressed and both the Police and Safeguarding Manager are in agreement the enquiry should be progressed.

Can I conclude the enquiry if the police are still investigating?

Dependent on the issue it may be possible to conclude the safeguarding enquiry from a Health or Social Care perspective, once the protection plan is in place. Awaiting the outcome of the crime can take a number of months and in some cases a year/s, holding a case open in light of this decision would not be appropriate if it has no bearing on the protection plan. Where this applies you may wish to consult the adult and allow them to make the decision as to whether they want the case leaving open until police processes are complete

NOTE

The adult may wish to have as one of their outcomes, that the person is arrested, charged and prosecuted, however we may not be able to agree this as an outcome we can deliver. The success of this outcome will be dependent on the evidence supporting the case, the view of the Crown Prosecution Service (CPS) and whether or not it is in the public interest to pursue the case through the courts.

Decision Making/Planning Meetings

In preparation of this meeting it may be appropriate to seek the view of the Adult at Risk in relation to where they would like meeting to be held. I.e. they may want this meeting to be held in their home.

In assessing who needs to be involved in the decision making/planning meeting, this will depend on the following:-

1. If the adult wants to attend to contribute and determine how their outcomes will be met.
2. If the adult does not want to attend and is happy for their views and outcomes to be fed into meeting.
3. The relationship between the safeguarding and other processes – disciplinary, complaint, etc.
4. The interface between the safeguarding processes and criminal processes.
5. If family based issues are present within the concern.
6. Whether the safeguarding concerns indicate that organisational abuse may need to be investigated.

1. Adult attendance at decision making/planning meeting

If the adult is attending the decisiion making/planning meeting, discussion with them is essential to ensure that they are clear about the purpose of the meeting and their role in it, there may be some information that they will legitimately not have access to – e.g.

- Criminal history of the alleged source of harm.
- Disciplinary action taken against the alleged source of harm prior to the current concern.
- Previous Safeguarding concerns involving the alleged source of harm.
- Personal information about the alleged source of harm relating to mental health, substance misuse and lack of mental capacity to make specific decisions etc.
- Other areas which impact on the right to confidentiality for either the alleged source of harm or the organisation they work with.

They will need to agree their role in the meeting with regard to:

- If they wish to be an observer and be supported to input to the meeting as they wish or do they want to be a driving force in directing the conversation and the agreed outcomes and responsibilities for those present at the meeting to realise their outcomes
- It will need to be made clear to them what information they will not have access to and why

- It will need to be agreed how they will be kept informed of the progress of the actions agreed – by a representative from each organisation or via a named representatives

2. Where the Adult at Risk does not wish to attend but is happy for their views to be fed into the meeting is to follow the same process as number 1.

3 & 4 Interface with other processes

Organisations need to be clear that the adult's outcomes may or may not include safeguarding, however it is likely that a decision on abuse will be required to support the Partnership Board to monitor abuse and trends to take preventative action and to report onto regulated bodies.

Adults may simply want an apology from the person/organisation – organisations lack of willingness to do this if the abuse has been substantiated may result in the adult making a formal complaint to the organisation where the alleged abuse occurred.
At the decision making/planning meeting agreement will be reached about which of the following process may be available to meet their outcomes:

- Criminal investigation
- Disciplinary
- Complaint
- Safeguarding Abuse definition – balance of probability decision
- Or a combination of the above

To support the success of the meeting, it is key that the organisation(s) involved: Support attendance by a relevant/knowledgeable professional who can clearly advise on what can and can't be achieved by the process to allow the adult to be clear in which options will meet their outcomes

5. Decision Making/Planning Meetings with Families

These should be considered in cases where

- The alleged source of harm and the adult are in a relationship and both wish to continue in the relationship and accept the need for change
- The adult lacks capacity to make a decision about involvement in these meetings and they have family members or friends who will provide a more effective advocacy than a paid service.

- Family members are the alleged source of harm **and** they accept both their role in causing the harm and the need to change.

Family member/s need to be aware of their responsibilities and the limits to their right to access information.
The following are areas where it is not appropriate to share the information:-

- Criminal history of the alleged source of harm
- Disciplinary action taken against the alleged source of harm prior to the current concern
- Previous Safeguarding concerns involving the alleged source of harm
- Personal information about the alleged source of harm relating to mental health, substance misuse, lack of mental capacity to make specific decisions etc.

Details of other adults who may have been affected by alleged abuse by the same source of harm

- Other areas which impact on the right to confidentiality for either the alleged source of harm or the organisation they work with

6. Organisational Abuse

Due to the duty of all professionals to maintain the confidentiality of individual adults, it is unlikely that the adult or their family will be invited to these decision making/planning meetings, however their individual outcome meetings/discussions should be shared at the meeting and inform the attendance of the involved professionals and agreed actions.

It should be agreed by the chair - who will feedback to the adult(s) about;

- Actions impacting on their individual outcomes
- Information about other actions relating to the alleged source of harm
- The adults role in decision making

If a formal outcomes meeting is held at the end of the enquiries the adult(s) or their representative/ advocate should be provided with information gathered via the individual S42 enquiry (reports) their individual outcomes and provided with an opportunity to contribute to the decision making. They will not be given access to information about other adults who may have been involved in an individual S42 enquiry even it is related to the same provider/organisation.

If the adult has indicated that one of their outcomes is a ‘decision on abuse’ (as defined in the Care Act/SY procedures) they must be supported to contribute to this either by attending the outcome meeting or providing their views via their agreed link person. If they decline to be involved their link person should provide them feedback from the enquiry and the decision on abuse.

In rare circumstances an outcome meeting may not be required as all of the outcomes agreed at the decision making/planning meeting may have been met by the organisation who led on the face to face meeting. In these cases the outcomes should be recorded on the outcome meeting form to maintain a record.

Possible attendees at Decision Making/Planning and Outcome meetings

The list below is not fully inclusive but offers guidance about which individuals/ organisations should be considered as appropriate

- The Adult at Risk of harm if they have consented to a S42 enquiry
- The Adults at Risk's advocate if required
- The Adult at Risk's IMCA if they lack capacity and a S42 enquiry has been agreed via a best interest meeting
- Housing provider
- Health – GP, nursing services, hospital staff, mental health, physiotherapists etc.
- Social care – social worker, social care services – domiciliary care etc.
- Police, safer and sustainable communities, etc.
- Housing support services
- Specific support services – age UK etc.
- CQC – if concerns exist about a registered manager or the organisation if registered with CQC and is subject to enforcement action
- Commissioning services – health and social care
- Any other organisations involved to progress the enquiry

Exclusions

In most circumstances the alleged source of harm will be excluded from the meeting unless: -

- The adult has a relationship with the alleged source of harm and has strongly indicated that they need to be part of the solution
- The alleged source of harm is either a worker or a manager in an organisation who is implicated in the abuse.

The Adult at Risk will be excluded if they have indicated that they do not agree with the decision to progress the enquiry, but others are at risk and they have maintained a relationship with the alleged source of harm

Example
The adult employs a personal assistant, who has been identified as the alleged source of harm; the personal assistant works with other adults. The adult who has

allegedly been harmed does not want any action taking and intends to continue to use the PA. Allowing them to attend the meeting would compromise the confidentiality and success of any enquiry as the adult may share the information with the PA

Agenda – Decision Making/Planning Meeting

- Introductions – name, role and relationship to adult
- Apologies or exclusions – state why individuals have been excluded
- Summary of concern and risk assessments
- Establish if any of the Adults at Risk of harm require specific capacity assessments and/or best interest decisions if not already assessed
- Summary of protection plan in place, if applicable, if not applicable does a protection plan for the adult or other adults need to be agreed
- What are the views of the adult, who is the subject of the concerns, (if they have agreed to a formal S42 enquiry, every effort should be made to support their attendance at this meeting). If they have not agreed to a S42 enquiry but it has been progressed due to risks to other adults their views must be shared and clearly recorded)
- Analysis of possible options to resolve the concerns – (using the tools provided) If more than one adult is at risk and the decision making/planning meeting is exploring organisational abuse, the individual risks must be addressed and recorded before addressing any additional actions to complete the S42 enquiry into the alleged organisational abuse.
- Agreement on what action will be taken, by whom and within what timescales
- Detail who will take responsibility for keeping the adult(s) updated on the progress of the enquiry and amending the S42 enquiry if their views change
- Name of the safeguarding manager overseeing the enquiry

If an overarching safeguarding enquiry is required in a health or social care settings, the guidance set out below will be helpful to assist practitioners to produce a high quality report for the outcome meeting

Dealing with Large Scale Investigations and Service-Level Concerns.

The following procedure is for large-scale investigations and service-level concerns.

A large-scale Safeguarding Adults investigation would be indicated when a number of adults have been allegedly abused, or patterns or trends are emerging from data that suggest concerns about poor quality of care:

- In a particular resource/establishment;
- Where the same person is suspected of causing the **Abuse** or Neglect;
- Where a group of individuals are alleged to be causing the harm.

See below Document for guidance with this process

Dealing with Large Scale Investigations a

Step 7

Outcome meetings

‘Outcome Meeting’ - range of options –including making judgment about whether abuse occurred *7 & Exit out of Section 42 Enquiry

Where required ‘Outcome Review Meeting’
Once complete Exit out of Section 42 Enquiry *8

In preparation of this meeting it may be appropriate to seek the view of the Adult at Risk in relation to where they would like meeting to be held. i.e. they may want this meeting to be held in their home

The purpose of an outcome meeting is to:

- Review whether the adult's outcomes have been met – fully, partially, or not met
- Assess if the adults risk have been removed, remain, increase
- Discuss how any remaining risks might be addressed for the adult and/or other Adults at Risk
- Evaluate their satisfaction with the process and the outcomes
- Identify if any other actions are required to improve practice or to reinforce protection plan etc.

The outcome meeting may include any (or a combination) of the below:-

- ✓ Face to face meeting with the adult if the outcomes agreed at planning stage only involved one organisation and the adult does not want a decision on abuse

- ✓ An informal meeting with a number of agencies with a chair agreed between the agencies – to discuss agreed outcomes that cover either more than one organisation or more than one process – complaint/disciplinary etc.

- ✓ A family outcome meeting to evaluate if the actions from the decision making/planning meeting have been achieved and to explore if any further actions are required to keep the adult safe (the adult must agree to these if they have capacity/ If they lack capacity a best interest decision should be reached in advance of the meeting

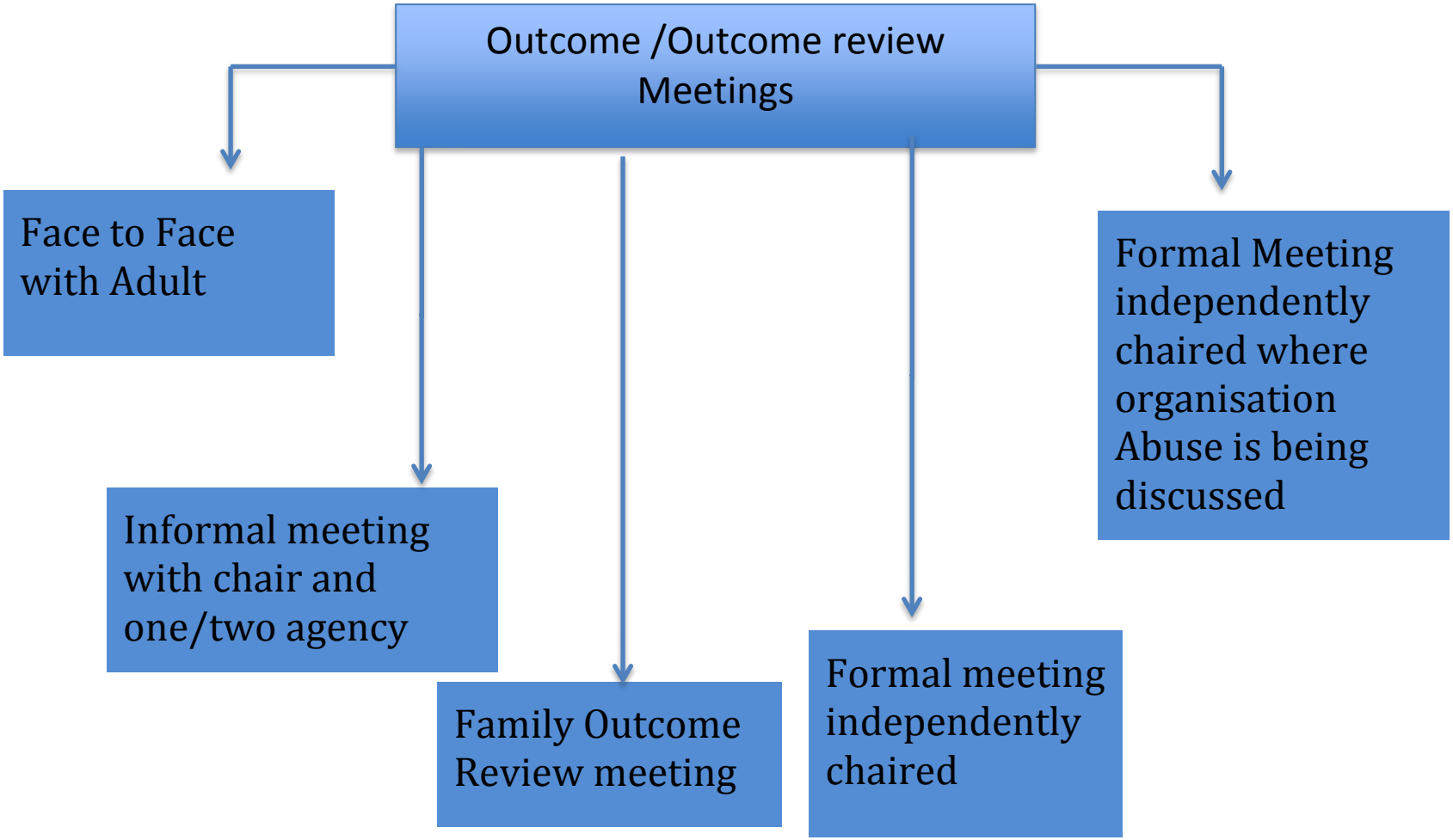
- ✓ A formal meeting with an independent chair- to discuss outcomes were the adult remains unsafe, is dissatisfied with the progress against the agreed outcomes or a decision is needed on whether or not abuse has been substantiated

- ✓ A formal meeting with an independent chair to discuss organisational abuse, this should follow any individual outcome meetings and the findings from these should be included in the meeting. A decision on abuse must be reached and an independent chair should be involved.

The level of recording of these meetings will vary from a very short set of notes about if the outcomes have been met and if not if any other action can be reasonably be taken to reduce any outstanding risks to a more formal set of minutes to record the outcomes/ abuse decisions and identification of any ongoing risks and protection plan.

Step 7 & 8

Outcome Meetings and Outcome review meeting – options



Outcome Review Meeting

The outcome review meeting is to review any outstanding actions made at the outcome meeting and to ensure the protection plan agreed at that meeting is working and the Adult at Risk is supported and enabled to manage any remaining risks

These may include any (or a combination) of the below:-

- ✓ Face to face meeting with the adult to review if the outcomes agreed at the outcome meeting are still relevant and the protection plan developed enables the adult to manage any remaining risk. This could involve one or two organisations involved in supporting the adult

- ✓ An informal meeting with a number of agencies with a chair agreed between the agencies – to review the outcomes and protection plan that covers more than one agency or more than one process – complaint/disciplinary etc.

- ✓ A family outcome review meeting to evaluate if the actions from the outcome meeting have been maintained and the protection plan continues to enable the adult to manage their risk with or without support from family, agencies etc.

- ✓ A formal outcome review meeting with an independent chair- to discuss any outstanding actions from the outcome meeting and to review the protection plan to ensure the adult is supported to manage their risk were the adult remains unsafe, is dissatisfied with the progress against the agreed outcomes.

- ✓ A formal meeting with an independent chair to review the outcomes agreed at the previous meeting, pick up any outstanding actions and review the overarching risks and outcomes that support organisational abuse, this should follow any individual outcome meetings and the findings from these should be included in the meeting. Pick up any feedback from regulatory bodies where referrals have been made. i.e. Disclosure Vetting and Barring Service, Nursing & Midwifery Council NMC, Health & Social Care Professions Council HCPC.

The level of recording of these meetings will vary from a very short set of notes to formal notes, depending on the type of meeting arranged The review will cover whether the protection plan is still relevant and the risk remain, are reduced or are removed.
If any actions are carried over from the outcome meeting, the outcome review meeting recorded if these actions have been met along with any changes made to the protection plan.

Information Provided to the Safeguarding Adults Board (SAB)

One of the requirements of the Care Act 2014 is that each local authority must set up a Safeguarding Adults Board (SAB) (see **Safeguarding Adults Board Procedure**).

In order to carry out its functions, SABs will need access to information that a wide number of people or other organisations may hold. Some of these may be SAB members, such as the NHS and the police. Others will not be, such as private health and care providers or housing providers/housing support providers or education providers.

In the past, there have been instances where the withholding of information has prevented organisations being fully able to understand what "went wrong". This has hindered them identifying the lessons to be applied to prevent or reduce the risks of such cases reoccurring. If someone knows that abuse or neglect is happening they must act upon that knowledge, not wait to be asked for information.

A SAB may request a person to supply information to it or to another person. Under the Care Act, the person who receives the request must provide the information provided to the SAB 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 and then either:
    i. The information requested relates to the person to whom the request is made and their functions or activities; or
    ii. The information requested has already been supplied to another person subject to a SAB request for information.

APPENDIX 1

Information Sharing

Contents

1. Introduction

The aim of this chapter is to facilitate and provide clear guidance on the exchange of personal and sensitive information for the investigation and responding to suspected Abuse and neglect of adults within South Yorkshire. Signatory organisations to the Safeguarding Adults Procedures have already committed to working together on the identification, investigation, treatment and prevention of abuse or mistreatment of Adults at Risk. This chapter provides a clear basis for operational staff to improve information exchanges to support earlier identification, prevention, investigation and treatment of abuse of Adults at Risk.

No Secrets, Department of Health (2000) states that the government expects organisations to be sharing information about individuals who may be at risk from abuse. It is important to identify an abusive situation as early as possible so that the individual can be protected. Withholding information may lead to abuse not being dealt with early enough. Confidentiality must never be confused with secrecy.

ADD in CARE ACT

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

It applies to information sharing in relation to situations involving Adults who meet the criteria for Safeguarding Adults interventions: any adult ' CHANGE DEFINITION TO CARE ACT '. The chapter applies to all organisations with responsibilities for the provision of either assessments or services under these Procedures.

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

2. Purpose of Information Sharing.

The information exchanged under this chapter will only be used for Safeguarding Adults purposes and where it meets these conditions:

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

This chapter has been approved only for the purposes listed above.

If other reasons for sharing information are subsequently identified, these will be considered and amendments approved by the appropriate Caldicott Guardian of the partner organisations. The parties to the agreement may share information for other purposes as stipulated in other Service Level Information Sharing Protocols.

3. Information Sharing when the Adult has Capacity to Consent.

There are situations where information can be shared legally without obtaining the consent from an individual. An element of information sharing will need to happen as part of the Decision Making/Planning Meeting where initial assessments of the risk factors affecting an adult at risk is made.

In this situation information can be shared without consent, relying upon statutory powers and duties. As part of the Decision Making/Planning Meeting the following decisions will be made:

- Any legal requirement to gain consent;
- When and who will gain consent if required.

Even if there is no legal requirement to obtain consent before sharing information, it is often good practice to do so. The emphasis throughout this chapter is on obtaining the informed consent of the client to share information at the first point of contact.

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

Workers need to make sure that the adult understands what will be recorded, what the information will be used for and with whom it might be shared. If the worker does not explain this, they will not be able to give valid informed consent for information sharing to take place.

The following information should be recorded clearly within their own organisation's record when consent to share information has been freely given:

- Why the information needs to be shared;
- What information the service user has consented to be shared;
- Who the service user has consented for the information to be passed to, and any limitations to this;
- That this has been explained to the service user and they understand the implications of giving consent to share their information;
- Any comments made by the service user in relation to the disclosure;
- Date consent given;
- Decisions to refer/not to refer.

Consent should be reviewed through existing working practices, for example, when the service user's personal circumstances change, or an investigation is in progress.

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

- Confidential to the employing organisation and can be shared within that organisation;
- Should only be used for the purposes for which it was intended;
- Can be shared with another organisation either when:
- Permission is given by the person about whom the information is held;
- There is an overriding justification, statutory power or duty to share information without the person's consent

4. Information Sharing when the Adult does not have the Capacity to Consent to Information Sharing

Upon reaching the age of 18, no one else can take decisions on their behalf. If an adult is not competent to take their own decisions, professionals should share information that is in their 'best interests'. The capacity to be able to give consent can be assessed by considering:

- Has the person got the ability or power to make a particular decision;
- Have they got the ability to understand and retain the information relevant to the decision;
- Will they be able to understand the reasonably foreseeable consequences of deciding one way or the other;
- Will they have the ability to communicate the decision they have come to.

Where a person is not the legal representative but acts as 'carer' to a person not capable of giving consent, a mental capacity assessment and best interest decision should be undertaken. See Section 5, Best Interest below.

5. Best Interest.

The Mental Capacity Act 2005 and the Code of Practice set out the best interest's checklist to which professionals must have regard when determining what is in the best interests of an individual.

Where an Adult at Risk is judged to lack Capacity in relation to a specific decision, this decision should be made in their 'best interests'.

In the context of determining whether or not medical treatment should be provided to someone who lacks capacity, the House of Lords has defined best interest as an intervention which is:

'*Necessary to save life or prevent deterioration or ensure an improvement in the patient's physical or mental health; and in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question*.' (Code of Practice: Mental Health Act 1983)

In other aspects of decision making, particularly in relation to information sharing, the law is less clear. However, the Law Commission has recommended that in deciding what is in a person's best interests consideration should be given to the following:

1. Ascertainable past and present wishes and feelings of the person concerned and the factors the person would consider if able to do so;
2. The need to encourage the person to participate as fully as possible in decisions;
3. The views of other people whom it is appropriate and practical to consult about the person's wishes and feelings and what would be in their best interests;
4. Any person named by the client as someone to be consulted on those matters.
5. Anyone (whether a spouse, relative, friend or other person) engaged in caring for the client or interested in the client's welfare.
6. The holder of any lasting power of attorney.
7. Any deputy appointed for him by the court.
8. Achieving the purpose of an action or decision by means which least restrict the freedom of action of the person.
9. If someone is unable to give consent and there is no-one to represent them, we should record that they cannot give consent and only share information where necessary in their best interests or where we have a statutory duty to provide care.
10. If an adult is unable to give informed consent, then decisions to disclose information will generally be taken by the professional concerned. Any

decision should take into account the person's best interests and as necessary the views of relatives and carers. An earlier refusal to particular information being passed on, given while the person had capacity to decide, should normally be regarded as decisive.

11. Where a service user's capacity may change from day to day (for example as a consequence of fluctuating mental health), a decision on consent should be deferred wherever possible, until such a time as they are able to be involved in the decision making process, as long as this does not adversely impact on the vulnerability of the adult.

12. Where it is considered that a service user does not have the capacity, a record should be made of this decision and the steps taken by the professional to reach a decision about whether information should be shared.

6. Information Sharing when the Adult at Risk withholds Consent to Share Information

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

The need to protect the individual or the wider public outweighs their rights to confidentiality. Decisions to share information about the Adult at Risk must be made by the organisation and not that member of staff acting on their own. This, however, should not cause unnecessary delay in the disclosure process.

The worker must explain to the person why the disclosure needs to take place and to whom the information will be passed. This should generally be done unless it would increase the risks of harm.

The person's decision to withhold consent to share information must be recorded, along with any further decisions to sharing information.

Any decisions to share information without consent must not interfere with that person's human rights.

7. Sharing Information with Carers, Parents, Family, Partners

When the Adult at Risk has the Capacity to make the decision, it should be up to them to decide what information is disclosed to their carers/ parents/ family/ partners, and records should reflect this.

When the adult does not have the capacity, consideration should be given to when to share information with carers/parents of the Adult at Risk. In addition, consideration must be given to the relationship between the carers/parents and the alleged abuser. Clear decisions should be recorded about when and what to share, as well as whom is the most appropriate person to talk to the parent/carer. Generally some assessment should be made as to whether the sharing of certain information with a particular person or organisation is in the adult's best interests. This should all form part of the decision making in the best interest decision.

8. Sharing Information with Third Parties about the (alleged) Abuser

Organisations and workers must 'honestly and reasonably believe' that the sharing of information is necessary to protect an Adult at Risk or the wider public and must use the test of 'pressing social need'. To pass this test the relevant organisation must consider the following issues:

- How strong is the belief in the truth of the particular allegation? The greater the conviction that the allegation is true, the more compelling the need for disclosure;
- What is the interest of the third party in receiving the information? The greater the legitimacy of the interest in the third party in having the information, the more important need to disclose;
- What is the degree of risk posed by the individual if disclosure is not made?

Decisions about who needs to know and what needs to be known should be taken on a case by case basis. It is vital there is a balancing exercise undertaken weighing the serious consequences of disclosure against risks to Adult at Risk. Clearly the issue of proportionality will be vital.

This decision will be made at the decision making/planning meeting stage, where it will be determined who within the investigation team will contact and speak to the alleged source of harm and how this will be managed.

9. Disclosures to other Organisations Outside of the Safeguarding Outcomes Meeting.

The exception to disclosure outside of the safeguarding process will be where the risk posed by an individual in the community cannot be managed without the disclosure of some information to a third party outside statutory organisations. An example of this may include an employer, voluntary group organiser or church leader who has a position of responsibility/control over the individual and other persons who may be at serious risk.

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

- The individual presents a risk of serious harm to the Adult at Risk, or to those for whom the recipient of the information has responsibility. The right person will be the person who needs to know in order to avoid or prevent the risks;

- There is no other practical, less intrusive means of protecting the Adult at Risk, and failure to disclose would put them in danger. Also, only that information which is necessary to prevent harm should be disclosed, which will rarely be all the information available;

- The risk to the individual should be considered although it should not outweigh the potential risk to others were disclosure not to be made. The individual retains his rights (most importantly his Article 2 right to life) and consideration must be given to whether those rights are endangered as a consequence of the disclosure;

- The disclosure is to the right person and that they understand the confidential and sensitive nature of the information they have received. The information will not be disclosed by the recipient third party without the express permission of the original disclosing organisation. Consider consulting the individual about the proposed disclosure. This should be done in all cases, unless to do so would not be safe or appropriate. If it is possible and appropriate to obtain the individual's consent, then a number of potential objections to the disclosure are overcome. Equally, the individual may wish to leave the placement rather than have any disclosure made. If appropriate, this would also avoid the need for disclosure;

- Ensure that whoever has been given the information knows what to do with it. Again, where this is a specific person, this may be less problematic but in the case of an employer, for example, advice and support may need to be given.

10. Access and Security

See also Recording Information Procedure.

Access to personal information must be adequately protected from unauthorised or inappropriate access. All organisations must implement and maintain appropriate security measures to protect confidentiality, integrity and availability of personal information.

Adopted security measures must be effectively communicated to all staff and system users, detailing individual roles and responsibilities. System users must be provided with sufficiently detailed training to enable them to undertake their duties and maintain information security.

APPENDIX 2

Judging 'substantial difficulty' in being involved
Local authorities must consider for each person, whether they would have substantial difficulty in engaging with the local authority care and support processes. The Care Act defines four areas in any one of which a substantial difficulty might be found: -

Understanding relevant information

1.'Understanding relevant information'. Many people can be supported to understand relevant information, if it is presented appropriately and if time is taken to explain it. Some people, however, will not be able to understand relevant information, for example if they have mid-stage or advanced dementia.

Retaining information

2.'Retaining information'. If a person is unable to retain information long enough to be able to weigh up options and make decisions, then they are likely to have substantial difficulty in engaging and being involved in the process.

Using or weighing the information as part of engaging

3.*'Using or weighing the information as part of the process of being involved.'* A person must be able to weigh up information, in order to participate fully and express preferences for or choose between options. For example, they need to be able to weigh up the advantages and disadvantages of moving into a care home or terminating an undermining relationship. If they are unable to do this, they will have substantial difficulty in engaging and being involved in the process.

Communicating their views, wishes and feelings

4.*'Communicating their views, wishes and feelings'*. A person must be able to communicate their views, wishes and feelings whether by talking, writing, signing or any other means, to aid the decision process and to make priorities clear. If they are unable to do this, they will have substantial difficulty in engaging and being involved in the process.

APPENDIX 3

This is what you have told us you would like to see happen about the safeguarding concern

1. **……**

2. **……**

This is what we have agreed to do next

1. **……**

2. **……**

3. **……**

How will my Safeguarding concern be dealt with?

Everyone has the right To be Safe, Respected and Heard

What support will I receive to make me feel safe?

You have been given this leaflet because concerns around you or a member of your family's well-being have been raised and a 'safeguarding concern' has been made to the Safeguarding Adults Service.

This is known as a safeguarding enquiry.

Your personal contact is……

Your personal contact will keep you informed about what is happening.

You can contact them on ……if, at any time, if you have any questions, comments or concerns

What will happen next?	How will I be involved?	When will this happen?
Based on the concern and in taking account of your views and wishes, a 'decision making/planning meeting or discussion involving relevant staff/ agencies will take place to plan how to proceed with the Enquiry.	You will be asked if you wish to attend all or, part of this meeting depending on the circumstances of the case. If you would like to attend you could bring along someone to support you at the meeting and the meeting could be held at a place of your choice, e.g. your own home. If you do not want to attend, your views will be represented by your personal contact or advocate within the meeting/ discussion.	Within a maximum of 10 working days (2 weeks)

Enquiries will be made with the relevant people involved to find out more about what happened and to gather evidence to confirm whether the concern reported is abuse.	Throughout this enquiry contact will be maintained throughout and you will be kept up to date on the progress of the enquiry. Where required a protection plan will be put in place to support you.	To be completed within 6 weeks ~~fo~~of your face to face meeting
An 'outcome meeting' will be held involving all the relevant people to discuss the findings and your future support needs.	You will be asked if you wish to attend this meeting and you could bring someone along with you if you wish. The meeting can be held at a place of your choice, e.g. your home. You do not have to attend; a representative may attend in your place.	Within 23 weeks of the Section 42 enquiry commencing

Will I be kept informed?

Yes, …… will visit you before and after each meeting to find out how you are feeling and to check with you that the actions we are taking to support you are still in line with your original expressed outcomes.

People who may be involved

- Doctors and hospital staff
- District nurses
- Social workers
- Community psychiatric nurses
- Learning disability nurses
- Home care workers
- Managers or staff working in residential or nursing homes
- Police
- Housing wardens
- Advocacy

All of the above named professionals and organisations work together to safeguard adults in South Yorkshire.

Customer Satisfaction

You will be given the opportunity at the end of the enquiry to share with us your views and experience of the quality of the service received; this is so that we can improve our services

What if I want to complain?

If you have any concerns or complaints relating to this you can talk about these to

Your personal contact …….

If you want to talk to someone else you can speak to:

…….. on ……

APPENDIX 4

Mental Capacity and Deprivation of Liberty Safeguards

SCOPE OF THIS CHAPTER

This is a summary of the **Deprivation of Liberty Safeguards (DoLS)** http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm and its implications for health and social care professionals. It is not intended to be a replacement for the **DoLS Code of Practice (CoP)** http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476 Professionals must refer to the **Mental Capacity Act (MCA)** (http://www.legislation.gov.uk/ukpga/2005/9/contents and DoLS CoP for guidance on specific cases and to inform decisions.

Note that there is currently a Review of the Mental Capacity Act 2005, which includes a review of the Deprivation of Liberty Safeguards. This may have future implications for this chapter.

RELATED GUIDANCE

Deprivation of Liberty Safeguards Code of Practice
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
Department of Health Advice Note (28 March 2014)
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300106/DH_Note_re_Supreme_Court_DoLS_Judgment.pdf

Care Quality Commission - Briefing for providers on the Deprivation of Liberty Safeguards (April 2014)
http://www.cqc.org.uk/sites/default/files/media/documents/20140416_supreme_court_judgment_on_deprivation_of_liberty_briefing_v2.pdf

Contents

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1. Introduction

The **Mental Capacity Act 2005 (MCA 2005)** (**http://www.legislation.gov.uk/ukpga/2005/9/contents**) is designed to protect and restore power to **adults** who may lack or have reduced **Capacity** to make certain decisions at certain times. 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. An individual is deemed to lack Capacity if at the time he/she is unable to make a decision because of an impairment or disturbance in the functioning of the mind or brain. This may be temporary or permanent. Capacity is fluctuating and relevant to that moment in time.

Professionals and other staff need to understand and always work in line with the Mental Capacity Act. They should use their professional judgement and balance many competing views. They will need considerable guidance and support from their employers if they are to help adults manage risk in ways and put them 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.

2. Principles of the Act

The following 5 principles apply for the purposes of this Act:

- A person must be assumed to have Capacity unless it is established that s/he lacks Capacity;

- A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success;
- A person is not to be treated as unable to make a decision merely because s/he makes an unwise or bad decision;
- An act done or decision made, under the Act for or on behalf of a person who lacks Capacity must be done, or made, in his best interests
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

For example: before 'restraining' someone in a chair due to the risk of falling could other less restrictive preventative measures work? These may include more intensive or even 1:1 observations or placing the person on more appropriate seating.

Remember that the Mental Capacity Act 2005 is designed to restore power and to protect.

The five principles of the Act are the starting point. They should inform all actions when working with a person who may lack or have reduced Capacity. The five principles should be evidenced in taking any decisions or actions for a person who you consider may lack or have reduced Capacity.

An assessment must be made as to whether the living arrangements made for a mentally incapacitated person amount to a deprivation of liberty. If they do, then the deprivation has to be authorised (either by the Deprivation of Liberty Safeguards (hospitals/care homes) or by the **Court of Protection** (domestic settings such as supported living arrangements), and subject to regular independent checks.

3. Mental Capacity and Safeguarding

Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the MCA in adult Safeguarding Enquiries challenges many professionals and requires utmost care, particularly where it appears an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected.

3.1 Ill Treatment and Willful Neglect

The MCA created the criminal offences of ill-treatment and willful 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 - paid staff but also family carers as well as 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 also those acts which are reckless which results in ill treatment.

Willful 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.

3.2 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 the action it takes. The OPG can also make an application to the Court of Protection if it needs to take possible action against the attorney or deputy. Whilst the OPG primarily investigates financial abuse, it is important to note that 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.

4. Deprivation of Liberty Safeguards

This amendment to the Mental Capacity Act 2005 (introduced by the Mental Health Act 2007) is to provide for procedures to authorise the deprivation of liberty of a person in a hospital or care home who lacks Capacity to consent to being there. These are known as the MCA Deprivation of Liberty Safeguards (MCA DOLS). 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.

The MCA DOLS cover:

- How an application for authorisation should be applied for;
- How an application for authorisation should be assessed;
- The requirements that must be fulfilled for an authorisation to be given;
- How an authorisation should be reviewed;
- What support and representation must be provided for people who are subject to an authorisation; and
- How people can challenge authorisations.

Their purpose is to secure independent professional assessment of:

a. Whether the person concerned lacks the Capacity to make his/her own decision about whether to be accommodated in the hospital or care home for care or treatment; and

b. Whether it is in his/her best interests to be detained.

5. 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)**
http://www.legislation.gov.uk/ukpga/2005/9/contents
can be lawfully carried out in someone's best interest to prevent harm. This includes use of physical restraint where that is proportionate to the risk of harm to the person and in line with best practice. Neither the Mental Capacity Act nor DoLS can be used to justify the use of restraint for the protection of members of staff or other service users or patients.
The difference between restriction of movement and deprivation of liberty is based on degree and intensity.

It is likely some organisations, such as hospitals and care homes, are failing to recognise when they are depriving a patient of their liberty, and are therefore breaching the law. It is also possible that the Mental Health Act 1983 is being used inappropriately to keep a patient in hospital, when the patient should, instead, be restrained following section 5 of the Mental Capacity Act 2005.

Unlawful deprivation of liberty is unacceptable. If an organisation breaches this basic human right, the risks to the organisation could include: a court declaration that the organisation has acted unlawfully and breached the adult's human rights, a claim for compensation, negative press attention and unwanted attention from commissioners and regulators.

Revised Test for Deprivation of Liberty

The Supreme Court has clarified (P v Cheshire West and Chester Council and P&Q v Surrey County Council, March 2014) that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights where the person:

- Is under continuous supervision and control; and
- Is not free to leave; and
- Lacks Capacity to consent to these arrangements.

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.

This test is far broader than those set by previous judgements - disabled people should not face a tougher standard for being deprived of their liberty than non-disabled people.
The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement in the community. These must be authorised by the **Court of Protection**.

This ruling will have implications for practice and the DH Advice Note (March 2014) states that: Relevant Staff should:

- Familiarise themselves with the provisions of the MCA, in particular the five principles and specifically “the least restrictive” principle;
- When designing and implementing new care and treatment plans for individuals lacking capacity, be alert to any restrictions and restraint which may be of a degree or intensity that mean an individual is being, or is likely to be, deprived of their liberty (following the revised test supplied by the Supreme Court);
- Where a potential deprivation of liberty is identified, a full exploration of the alternative ways of providing the care and/ or treatment should be undertaken, in order to identify any less restrictive ways of providing that care which will avoid a deprivation of liberty.

Local Authorities should:

- Review their allocation of resources in light of the revised test given by the Supreme Court to ensure they meet their legal responsibilities;
- Ensure awareness of the Supreme Court judgment among care providers;
- Ensure awareness of the need to reduce restraint and restrictions and promote liberty in care plans;
- Map any additional requirements for Best Interest Assessors (BIAs) and working collaboratively with other Local Authorities to reduce training costs;
- Review information on the number of individuals in supported living arrangements to identify those individuals whose arrangements should be reviewed.

Other chapters in this manual that will be affected by this ruling are:

Coroner Procedure.

Commissioning and Provider Services Procedure.

Authorising a Deprivation of Liberty

The DoLS process for obtaining a standard authorisation or urgent authorisation can be used where individuals lacking Capacity are deprived of their liberty in a hospital or care home.

The Court of Protection can also make an order authorising a deprivation of liberty; this is the only route available for authorising deprivation of liberty in domestic settings such as supported living arrangements. This route is also available for complex cases in hospital and/ or care home settings.

Individuals may also be deprived of their liberty under the Mental Health Act if the requirements for detention under that Act are met.

6. Care Homes and Hospital Settings

Care homes and hospital wards have responsibilities under DoLS to ensure that none of their residents/patients are deprived of their liberty without the appropriate authorisation.

6.1 Local Authority Role

DoLS authorisations will be issued, where appropriate, following statutory assessments.

Local authorities have responsibilities under the safeguards to:

- Carry out the functions of the Supervisory Body as detailed in the DoLS Code of Practice;
- Receive requests for authorisations from care homes and hospitals;
- Commission statutory assessments and granting Deprivation of Liberty authorisations where appropriate.

The Safeguards also apply to privately arranged care, i.e. self-funded residential care.

Local authorities have a responsibility to protect the human rights of all Adults at Risk of harm, particularly in reference to these safeguards, those who may be at risk of deprivation of liberty.

The **Department of Health Advice Note (March2014(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300106/DH_Note_re_Supreme_Court_DoLS_Judgment.pdf**

stated that relevant staff in local authorities and care providers should 'take steps to review existing care and treatment plans for individuals lacking Capacity to determine if there is a 'deprivation of liberty' in the light of the Supreme Court ruling. Where people are deprived of their liberty – and this is judged to be in their best interests – this must be authorised.

6.2 Care Home and Hospital Roles

It is the responsibility of the care home manager or hospital to decide whether the care required amounts to deprivation of liberty. If so, they must apply for an authorisation or reduce the restrictions so that deprivation of liberty is avoided.

DoLS authorisations will only be granted if:

- It is in a person's own best interests to protect them from harm;
- It is a proportionate response to the likelihood and seriousness of the harm; AND
- There is no less restrictive alternative.

6.3 Requesting an Authorisation

Care homes and hospital wards should request an authorisation when appropriate using the standard forms.

They may also grant themselves an Urgent Authorisation for up to 7 days, but must notify the DoLS office and apply for a standard authorisation at the same time.

See **Chapter 6, DoLS Code of Practice**
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

6.4 DOLS Assessment Process

Before a local authority can grant an authorisation, at least two separate assessors must carry out the following:

1. **Mental health assessment** - to confirm whether the person has an impairment/disturbance in the mind or brain;
2. **Eligibility assessment** - to confirm the person's existing or potential status under the Mental Health Act, and whether it would conflict with a DoLS authorisation;

3. **Mental capacity assessment** - carried out by either the Mental Health or Best Interest Assessor to determine the person's capacity to consent to the care proposed;
4. **Best interest assessment** - to confirm whether deprivation of liberty is occurring, whether it could be avoided, and whether it is in the person's best interest. They will also recommend, how long the authorisation should last and who should act as a person's representative throughout the period of authorisation;
5. **Age assessment** - to confirm the person is at least 18 years of age;
6. **No Refusals assessment** - to confirm whether there is any valid advanced decision which would conflict with the authorisation, or a person with a valid and registered **Lasting Power of Attorney** with authority over welfare decisions.

An IMCA (**Independent Mental Capacity Advocate**) may also be appointed during the assessment process if required.

If any of the qualifying requirements are not met, the authorisation cannot be granted.

An authorisation can be granted for a maximum of 12 months, but will usually be agreed for a shorter time period as appropriate for the individual concerned.

6.5 Role of the Person's Representative

See **Chapter 7, DoLS Code of Practice**
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Everyone who is subject to an authorisation will be appointed a representative. They must maintain face to face contact with the person and represent and support them in all matters relating to the Deprivation of Liberty safeguards, including, if appropriate, requesting a review, or applying to the **Court of Protection** to present a challenge.

The representative has the right to request the advice and support of an IMCA.

If there is no family member, friend, or informal carer suitable to be the person's representative, the DoLS office will appoint a paid representative.

The name of the person's representative should be recorded in the person's health and social care records.

6.6 Reviews

It is the responsibility of the care home or hospital ward to monitor and review the person's care needs on a regular basis, and report any change in need or

circumstances that would affect the deprivation of liberty authorisation or any attached conditions.

The care home or hospital must request a DoLS review if:

- The relevant person no longer meets any qualifying requirements;
- The reasons the person meets the qualifying requirements have changed;
- Because of a change in the person's situation, it would be appropriate to add, amend or delete a condition placed on the authorisation.

The person or their representative may also request a DoLS review at any time.

The DoLS Service will commission assessors to carry out a review of an authorisation when statutory conditions are met. Statutory DoLS reviews will not replace health or social care reviews.

6.7 Alerting unlawful Deprivation of Liberty

If a person (professional or otherwise) suspect's unauthorised deprivation of liberty, they should discuss it with the care home manager/hospital ward manager.

If the care home/hospital agrees that the care plan involves deprivation of liberty, they should be encouraged to make a request for authorisation.

All parties should be satisfied that the Care Plan is the least restrictive option available to keep the person safe, and that it is in the person's best interest.
If the care home does not agree to make a request for a DoLS authorisation, the care manager/coordinator can then approach the DoLS office to discuss the situation and report the unlawful deprivation.

6.8 DOLS and Adult Protection Alerts

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 so the person has access to the safeguards and is appropriately represented throughout the authorisation.

An Adult Protection/Safeguarding Concern may be appropriate if there is also an allegation or concern of abuse, harm or neglect. If so, **Part 2, The Safeguarding Process - Management of Individual Cases** - should be followed.

6.9 Working with DOLS Best Interest Assessors

Best Interest Assessors and the DoLS Service will not, at any point, have responsibility for care planning or care management/coordination.

The DoLS Code of Practice points out that there is a particular need for care management/coordination if a Best Interest Assessor finds a service user/patient is being deprived of their liberty under their current Care Plan, but that Care Plan is not seen to be in their best interest and the deprivation is not authorised. The care home/hospital ward needs to work with the care manager immediately to reduce restraint/restriction and ensure the person is not unlawfully deprived of their liberty.

The Best Interest Assessor's report will explain their conclusion and aim to make useful suggestions to commissioners and providers in determining future action including recommending alternative approach to treatment or care which would avoid deprivation of liberty. The Best Interest Assessor will discuss the possibility of any suggested alternatives with the providers of care during the DoLS assessment. This report should be kept on the person's file.

The recommendations of the Best Interest Assessor should not be seen as a commitment or agreement to additional resources being provided by the commissioning agency. Any additional resources which are required should be requested by the care provider and presented to the relevant funding panel according to existing arrangements and procedures.

The care home/hospital need to record the steps they have taken to ensure the unauthorised deprivation of liberty does not continue. The Best Interest Assessor's report should then be added to the person's file/Care Plan.

The care manager will be asked to complete a review of the person's needs and work with the managing authority to propose an alternate Care Plan. If the Care Plan has funding implications, the care manager will present an application to the relevant funding panel or responsible commissioner.

After an appropriate interval (no longer than one month) the DoLS office may arrange for a professional who has been trained to undertake best interest assessments to complete an independent review of the person's Care Plan on behalf of the local authority, to confirm that there is no longer a deprivation of liberty. If deprivation of liberty has continued unauthorised, the DoLS office will consider whether to raise a Safeguarding Concern.

If this is in the case of a proposed admission to residential care, that admission will need to be delayed until an alternative Care Plan is proposed that will not involve deprivation of liberty.

If the person is to be discharged from hospital, and considerations about potential deprivation of liberty are causing or contributing to delay in discharge planning, this should be discussed with the DoLS Office or the Safeguarding Adults Manager at the earliest opportunity.

7.Domestic Settings

The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement in the community. Where there is, or is likely to be a deprivation of liberty in such placements that must be authorised by the **Court of Protection**.

8. Legal Action to Safeguard Adults at Risk of Falling Outside the Mental Capacity Act 2005

The Court of Appeal, in the case of DL-v-a Local Authority and Others (2012), clarified that there may be scope for local authorities to commence proceedings in the High Court to safeguard adults who do not lack Capacity under the Mental Capacity Act, but whose ability to make decisions for themselves has been compromised by a reason other than mental incapacity because they are:

a. Under constraint.

b. Subject to coercion or undue influence.

c. For some other reason deprived of the Capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.

Whilst the Court did not attempt to define who might fall into this group, they quoted from an earlier case, which expanded upon these situations:

- **Constraint**: It does not matter for this purpose whether the constraint amounts to actual incarceration. The jurisdiction is exercisable whenever an adult is confined, controlled or under restraint…. It is enough that there is some significant curtailment of the freedom to do those things which in this country free men and women are entitled to do.

- **Coercion or undue influence**: The kind of vitiating circumstances, where an adult's Capacity or will to decide has been sapped and overborne by the improper influence of another. Where the influence is that of a parent or other close and dominating relative, and where the arguments and persuasion are based upon personal affection or duty, religious beliefs, powerful social or cultural conventions, or asserted social, familial or domestic obligations, the influence may be subtle, insidious, pervasive and powerful. In such cases, moreover, very little pressure may suffice to bring about the desired result.

- **Other disabling circumstances**: The many other circumstances that may so reduce an adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent, for example, the effects of deception, misinformation, physical disability,

illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others.

Case Law Example

The DL case concerned an elderly couple both of who, at the commencement of the proceedings, had Capacity under the Mental Capacity Act. The local authority was concerned about the behaviour of their adult son, who lived with them. The local authority had documented incidents over several years chronicling the son's behaviour, including physical assaults, verbal threats, controlling where and when his parents may move in the house, preventing them from leaving the house, and controlling who may visit them, and the terms upon which they may visit them, including health and social care professionals providing care and support for the mother. There had also been consistent reports that the son was seeking to coerce his father into transferring the ownership of the house into the son's name and that he has also placed considerable pressure on both his parents to have his mother moved into a care home against her wishes. The parents did not wish for proceedings to be taken against the son to protect them from his behaviour, as they wished to preserve their relationship with him. Injunctions were granted restraining the son's behaviour towards his parents, care staff and other professionals.

Note that this is a different situation requiring the local authority to act in a different way from Mental Capacity Act cases. If the Mental Capacity Act applies, then there is a specified legislative procedure. The local authority can take steps in accordance with this, without necessarily needing court approval. (Issues needing court determination would be heard in the Court of Protection.) Situations falling outside the Mental Capacity Act (i.e. where the adults in question do not lack Capacity under the Mental Capacity Act) would always require application to the High Court – there are no additional powers conferred upon local authorities. The inherent jurisdiction of the High Court is a 'safety-net', catching cases not prescribed by statute, and will necessarily be less clearly defined. Legal advice would need to be sought in all such situations.

9. Acting on Behalf of Someone Who Lacks Capacity

The MCA deals with two situations where a designated decision-maker can act on behalf of someone who lacks Capacity:

- **Lasting Powers of Attorney (LPA's)** - 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. Depending on the terms of their appointment, 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.

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 Office of the Public Guardian is the registering authority for LPA's and deputies. It supervises deputies appointed by the Court and provides information to help the Court make decisions. It 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 Office of the Public Guardian discharges its functions.

The MCA also includes 3 further key provisions to protect Adults at Risk of harm:

- **Independent Mental Capacity Advocates (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. IMCA services are provided by organisations that are independent of the NHS and local authorities;
- **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.

Further information can be found on the **Public Guardian website** **http://www.justice.gov.uk/about/opg**