

Safeguarding Adults in Islington

Multi-Agency Policy and Procedure

Updated March 2010

Islington Safeguarding Adults Partnership Board

Islington Safeguarding Adults Partnership Board



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Preface

The aim of this policy and procedure is reduce incidents of abuse or neglect of vulnerable adults. This policy and procedure sets out the role of all staff in the partnership.

This policy and procedure is based on Department of Health guidance published in 2000¹ and ADASS guidance published in 2005².

This policy and procedure is an updated version of that published in September 2008. The updates that have been made are:

- Formatting: to make the document easier to follow
- Terminology: replacement of 'CSCI' and 'POVA' with current terms 'CQC' and 'ISA'
- Preface: revised to reflect current version of this policy and procedure
- Sections: sections A and B have not been changed, except for the addition of a section relating to the 'Safeguarding Vulnerable Groups Act 2006'. Sections C, D and E have been changed. These were formerly:
 - Section C 'Procedures for Responding to Abuse'
 - Section D: 'Monitoring and Recording Concerns'
 - Section E: Practice NotesThese are now:
 - Section C: 'Basic Procedure'
 - Section D: 'Further Procedural Detail'
- Subsections: have been reorganised to make the basic process clearer. Some of the subsections have been adjusted to make them correspond more closely with guidance given by ADASS³. In particular, the timescales for action now match those recommended by ADASS. Apart from the change in timescales, the revision of the basic procedure does not entail a change in practice. These sections have simply been re-written to make them clearer.
- Appendices: appendices 4-6, 8, 10 and 14 have been replaced with more up-to-date versions.

¹ Department of Health (2000) *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.*

² ADASS (2005) *Safeguarding Adults: A National Framework of Standards.*

³ *Ibid.*

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A. Policy

1. Introduction

- 1.1 The primary aim of Islington Safeguarding Adults Partnership Board is to raise awareness of abuse, neglect or inadequate care to vulnerable adults, and seeks to do so by establishing a commitment to preventative measures and developing good practice across all organisations in Islington who have contact with vulnerable adults.
- 1.2 The local authority (London Borough of Islington) continues to have the lead responsibility for co-ordinating any safeguarding adults investigation.
- 1.3 All staff are committed to responding actively, promptly, and in a co-ordinated way to allegations of abuse or neglect that come to their notice. Their approach will take into account a person's race, cultural background, disability, age, gender and sexuality. Abuse can take effect in a number of ways, and is referred to with reference to the following categories:-
- Physical abuse
 - Sexual abuse
 - Psychological or Emotional abuse
 - Financial abuse
 - Neglect or acts of omission
 - Discriminatory abuse
 - Institutional abuse
- 1.4 Abuse is a violation of an individual's human and civil rights by any other person or persons over the life of the dependent individual. This policy and procedure relates to concerns about a person who is in a position of power (normally a family member or a member of staff) over the vulnerable person. An allegation of abuse by a stranger (a person unknown to the individual) should consider referral to the police if a criminal offence appears to have been committed, as indicated in [paragraph 5.6](#).
- 1.5 The policy and procedure which follows is designed as a base line from which staff can work in this area. They are not exhaustive, and it is recognised that more comprehensive guidelines may be useful for work with specific groups of people. This document provides a framework, however, for the use of common values, principles and procedures to be employed across work with all vulnerable adults in the department. Whilst Section B, 'Recognising Abuse', is for staff in any agencies that work with vulnerable adults, Section C, '*Basic Procedure*', is for local authority, Mental Health Trust and Learning Disability Partnership staff (social workers, other professionals and their managers) who may be involved in the investigation and co-ordination of a suspected abuse enquiry.
- 1.6 As a department, Adult Social Services is responsible for co-ordinating the response to cases of alleged or suspected abuse, and working with the police when they need to investigate. However, it is important to emphasise the need to approach this complex task in a multi-disciplinary way, recognising the value of professional knowledge, experience, and skills of a range of staff.

- 1.7 Each agency is committed to promoting and developing effective working relationships with other agencies in order to provide the best possible service to the vulnerable residents of Islington.
- 1.8 We are grateful for the assistance of colleagues in other departments and agencies in the preparation of this policy.

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2. Vulnerable Adults - Definition

- 2.1 Islington's policy and procedures apply only to vulnerable adults and do not seek to interfere with the actions any adult can take under the criminal or civil law to protect themselves.
- 2.2 An adult, someone over the age of eighteen, is vulnerable if, by reason of old age, infirmity or disability (including mental disorder within the meaning of the Mental Health Act 1983) s/he is unable to take care of her/himself or to protect her/himself from others. They are identified as either being in need of community care services or to be at risk of losing their independence or sense of wellbeing through the actions of others.
- 2.3 The people most likely to be assessed as vulnerable are those adults who:
- Are elderly and/or frail
 - Suffer from mental illness, including dementia
 - Have a physical or sensory disability
 - Have a learning disability
 - Suffer from a severe, incapacitating physical illness
 - Are a vulnerable carer – it is important to note that vulnerability may be a permanent or temporary state.
- 2.4 A multi-disciplinary approach to assessing the level of an adult's vulnerability is vital. Any communication difficulties must be recognised and addressed. Ultimately a carefully considered professional judgement will often need to be made as to a person's capacity to make informed decisions for her/himself, and the extent to which she/he is able to protect her/himself ([see chapter 25](#)).
- 2.5 **Vulnerable Adults and Refusal of Care/Self Neglect** – This guidance covers the protection of vulnerable adults in relation to scenarios where abuse and a perpetrator are identified. Cases where a vulnerable adult is significantly at risk exclusively because of their refusal of care, intervention and services are to be dealt with through the processes of Risk Assessment, Care Management and Care Programme Approach. There is guidance available for this including the application of the multi-agency Comprehensive Risk Assessment, which provides a tool for contingency planning and communication in managing a cohesive response to these scenarios. However, it is important to acknowledge that a failure by health and social care agencies to appropriately respond to a refusal of care and cases of self neglect may constitute the failure of the 'duty of care' and ultimately lead to abusive neglect or omission. ([See 4.4 re the criminal act of 'wilful neglect' by formal or family carers.](#))

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3. Values

- 3.1. The following values will inform and guide all work with vulnerable adults:
- Privacy – the right of individuals to be left alone or undisturbed, and free from intrusion or public attention into their affairs.
 - Dignity – all people will be treated with respect. Each individual's unique characteristics and intrinsic value will be recognised.
 - Independence – the right to act and think without reference to another person.
 - Choice – the opportunity to make both small and more significant life choices, with assistance as appropriate to understand context and options; the opportunity to make choices in the individual's own interest, exercising the choice to take risks.
 - Rights – the maintenance of all entitlements associated with citizenship, including full participation in the life of the community.
 - Fulfilment – the realisation of personal aspirations and abilities in all aspects of daily life; the development of competence in valued, meaningful skills and attributes.⁴

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4. The Legislative Framework

- 4.1. Procedures for responding to suspected abuse of vulnerable adults is not underpinned by a specific legislative framework as they are for children. Nevertheless a range of legislation does exist which may be applicable to the protection of vulnerable adults. Adult abuse can be dealt with under the criminal law. The application of which requires a joint approach by the police, Islington Housing & Adult Social Services and other relevant agencies. In cases of domestic violence, criminal and civil remedies exist ([see Appendix 1](#)).
- 4.2. The NHS and Community Care Act 1990 - Section 47, which requires Local Authorities to carry out assessments where people are in need of services, provides the general legislative framework for protecting vulnerable adults. Vulnerable adults who are abused or at risk should be regarded as having a high priority under this Act.
- 4.3. Other legislation, including the Mental Health Act 1983, which specifically deals with vulnerable adults who are mentally disordered, is more interventionist. This legislation should, as a rule, only be used as a last resort in cases of abuse and then only after multi-agency discussion.
- 4.4. The Mental Capacity Act implemented in April 2007 introduced a new criminal offence of ill treatment or wilful neglect of a person who lacks, or is believed to lack, mental capacity. At an early stage, if it appears that the vulnerable person may lack capacity to make any decision related to or arising as a result of the suspected abuse, there will be a need to consider whether to appoint an Independent Mental Capacity Advocate (IMCA). An IMCA should be appointed where the vulnerable adult is un-befriended – which in this context would mean there is no friend or family who can speak on their

⁴O'Brien (1981) *Five Service Accomplishments. In Homes are for Living In, SSI, 1989.*

behalf. Where all potential friends/family are either suspected or potential abusers or compromised by their connection to the suspected abuse(s), the vulnerable adult is likely to be regarded as un-befriended and an IMCA appointed.

- 4.5. The Safeguarding Vulnerable Groups Act 2006 introduced a new 'Vetting and Barring Scheme', to vet staff and volunteers, prior to them working with vulnerable groups. The Scheme is administered by the Independent Safeguarding Authority (ISA) and began in October 2009. It replaces the Protection of Vulnerable Adults (POVA) list.
- Under the scheme regulated activity providers are under a duty to make referrals to the ISA of the names of staff and volunteers who have been found to have harmed or put at risk of harm a child or a "vulnerable" adult. The ISA will make a judgement on the evidence whether the person should be barred from any future employment or activity with vulnerable adults. Professional regulators and local authorities also have a duty to refer as leads in safeguarding adults.⁵
 - Mechanisms introduced by the General Social Care Council will further complement and strengthen safeguards for the protection of 'vulnerable' adults, e.g. the professional register will be open to domiciliary care staff from 2008.
 - Responsibility for making a referral to the ISA and/or to relevant professional bodies such as the General Medical Council, Nursing and Midwifery Council and General Social Care Council, rests with the employer. Professional regulators including the CQC and local authorities also have a duty to refer as leads in safeguarding adults where the regulated activity provider is the subject of the referral or where they have failed to make the appropriate referral.
- 4.6. The proper and wise use of legislation should not be avoided, as in some instances abuse may constitute a criminal offence.
- 4.7. The relevant legislation and guidance are summarised in Appendix 1. It is important for the actual legislation to be consulted directly in relation to individual situations. Guidance can be sought from the Local Authority's Legal Section and/or the police, where necessary. If intervention under the Mental Health Act appears appropriate, an Approved Social Worker/Approved Mental Health Practitioner must be involved at an early stage.

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5. Guiding Principles

- 5.1. There is a duty to care and ensure that the interests and well being of vulnerable people are at the forefront in assessment and decision making in relation to care planning and any necessary protective action. Every person has the right to be advised of, and receive, a range of available services and support to meet their assessed needs.
- 5.2. There is a borough wide system for alerting Social Services to a concern about a vulnerable adult at risk of harm. Adult Social Services, ILDP and the Mental Health Trust have access to the central recording system for these alerts. All other partners,

⁵ Independent Safeguarding Authority Vetting and Barring Scheme www.isa.gov.org.uk

providers and members of the public should contact Adult Social Services Access Team ([see Appendix 11](#)) or the named worker or team directly to report concerns.

- 5.3. If it is established that Safeguarding Adult procedures are not appropriate to deal with the issue raised, other procedures can be used such as Complaints, Care Programme Approach (CPA) and Risk Assessment. The decision to follow such procedures instead of the safeguarding procedure must be agreed by the Safeguarding Manager and recorded in the service user's records.
- 5.4. An awareness of factors which contribute to the abuse and inadequate care of vulnerable adults will inform professional strategies to alleviate stressful, or 'at risk' situations.
- 5.5. It is recognised that caring, and being cared for, can occur within a context of complex human relationships. Power dynamics may involve issues of gender, race, finance, and the exercise of power in many different forms. These issues must be recognised when working with vulnerable adults in general, and particularly when investigating any allegation of abuse.
- 5.6. Vulnerable adults may be abused by a wide range of people including relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers.
- 5.7. Agencies not only have a responsibility to all vulnerable adults who have been abused but may also have responsibilities in relation to some perpetrators of abuse. The roles, powers and duties of the various agencies in relation to the perpetrator will vary depending on whether the latter is a member of staff, proprietor or service manager; a member of a recognised professional group; a volunteer or member of a community group such as a place of worship or social club; another service user who may, or may not, themselves be vulnerable; a spouse, relative or member of the person's social network; a carer, i.e. someone who is eligible for an assessment under the Carers Recognition and Services Act 1996; a neighbour, a member of the public or stranger; or a person who deliberately targets vulnerable people in order to exploit them.
- 5.8. Stranger abuse will warrant a different kind of response from that appropriate to abuse in an ongoing relationship or in a care location. Nevertheless, in some instances it may be appropriate to use the locally agreed inter-agency adult protection procedures to ensure that the vulnerable person receives the services and support they need. Such procedures may also be used when there is potential for harm to other vulnerable people.
- 5.9. Abuse can take place in any context. It may occur when a vulnerable adult lives alone or with a relative; it may occur within nursing, residential or day care settings, in hospitals, custodial situations, support services into people's homes, and other place previously assumed safe, or in public places.
- 5.10. The environment or the context in which the abuse has occurred will partly determine intervention. Nursing, residential care homes and placement schemes are subject to regulatory controls set out in legislation and relevant guidance. Day care settings are not currently regulated this way and require different types of monitoring and intervention to address similar risks. Paid care staff in domiciliary services may work

with little or no supervision or scrutiny, and unregulated locations such as sheltered housing may require particular vigilance. Personal and family relationships within domiciliary locations may be equally complex, making it difficult to make interventions.

- 5.11. Assessment of the environment, or context, is relevant, because exploitation, deception, misuse of authority, intimidation or coercion may render a vulnerable person incapable of making his or her own decisions. Thus, it may be important for the vulnerable adult to be away from the sphere of influence of the abusive person or the setting in order to be able to make a free choice about how to proceed. An initial rejection of help should not always be taken at face value.
- 5.12. A first response will be to listen carefully to what is being said by the person raising a concern or reporting an incident of alleged abuse, and to record this information immediately, and completely. If the person is considered to lack mental capacity to make decisions regarding their safety and has been subject to abuse or neglect, staff should refer to the locally agreed guidance on the criteria for engaging an IMCA in the decision-making process. Anyone receiving such concerns or allegations indicating a criminal offence has taken place must be mindful of the need to alert the Police or Adult Social Services as soon as possible, and of their duty to minimise the potential for contamination of evidence, to achieve a successful prosecution.
- 5.13. When intervention is necessary to reduce risk this should be made explicit to the person concerned and should be pursued in a manner which least disrupts the person's life and ensures their maximum involvement in decision-making.
- 5.14. In determining how serious or extensive abuse must be to justify intervention a useful starting point can be found in '*Who Decides*'. Building on the concept of significant harm introduced in the Children's Act, the Law Commission suggested that:
- 5.15. Harm should be taken to include not only ill treatment (Including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development. It can also include a general loss of trust in people following financial abuse by a carer or relative.
- 5.16. The seriousness of extent of the abuse is often not clear when anxiety is first expressed. It is important, therefore, when considering the appropriateness of intervention, to approach reports of incidents or allegations with an open mind. Any initial allegation made by a vulnerable adult should be recorded, using as closely as possible those words used by the individual.

What this means in practice is working through a process of assessment to evaluate:

- Is the person suffering harm or exploitation?
- Does the person suffering or causing harm/exploitation meet the NHS and Community Care Act 1990 eligibility criteria?
- Is the intervention in the best interest of the vulnerable adult fitting the criteria and/or in the public interest?
- Does the assessment account for the depth and conviction of the feelings of the person alleging the abuse?

B. Recognising Abuse

6. Introduction

- 6.1. Abuse of vulnerable people can be described as ‘a *violation of an individual’s human and civil rights by any other person or persons*⁶.
- 6.2. Abuse may consist of a single act or repeated acts. It may be physical, verbal, or psychological, it may be an act of neglect or an omission to act or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of the person subjected to it. There are seven recognised categories of abuse, as outlined in [section 1.3](#).
- 6.3. Abuse may be caused intentionally, or unintentionally, but nevertheless it causes significant harm or distress to the vulnerable person, either temporarily or over a period of time.
- 6.4. It is vital that workers are alert to and aware of different types of abuse, the behaviours associated with different types of abuse, possible signs and symptoms and their likely effects.
- 6.5. These guidelines are concerned with abuse that takes place in a variety of domestic and institutional settings and is perpetrated by someone who knows and/or has a relationship with the vulnerable person. The relationship is characterised by an imbalance of power and usually by the dependence of the vulnerable person on the perpetrator of the abuse who may be a care giver, partner, relative, friend, volunteer or someone who is employed to care. In some cases the alleged perpetrator may be a vulnerable adult her/himself. Department of Health guidance recommends an IMCA should always be appointed when the abuser is also a vulnerable person.
- 6.6. Abuse in domestic settings may occur in the context of long-standing poor relationships and/or carer stress. In some cases, a perpetrator may also suffer maltreatment by the person s/he cares for. Neglect and poor professional practice also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum; through to pervasive ill treatment or gross misconduct at the other end. Repeated instances of poor care may be an indication of more serious problems and this is referred to as institutional abuse.
- 6.7. Abuse may not always present itself as an acute situation demanding urgent attention. What is reported is often not an incident, but a general concern or possibly suspicion

⁶ Department of Health (2000). *Ibid*.

about the care of a person. Any concerns of this nature should be passed onto Social Services, as an Alert with as much background information as is possible without intrusive questioning or delaying the process of forwarding the concerns. The person may already be known to more than one agency, and it may only be after putting information from all involved agencies together that a clearer picture may emerge.

Cases of suspected abuse may be identified through:

- Self disclosure by the victim.
- A worker recognising signs/symptoms of abuse in the course of their work. For example, GP's and Practice Nurses can become aware of signs of abuse during routine visits, doctors and nurses in Accident and Emergency Departments may be alerted by physical signs of abuse and/or repeated admissions. Domiciliary, day care or respite care staff that have developed a relationship with a vulnerable person may find the latter confides in them their fears and concerns about the way in which they are treated.
- Reported concern by a third party. This could present as a generalised anxiety about the level and type of care provided, or as a specific allegation of abuse and could be reported by, for example, a friend or neighbour, or from another department or agency not directly involved with the individual's care.
- Carer reporting stress and problems in coping.

6.8. The identification of cases of abuse, even where there are physical signs of harm, is unlikely to be simple and will usually require the collation of information from a variety of sources. In addition, the current research available suggests that the victims of abuse do not always react in the same way. Some common reactions are:

- Denial (even in the face of strong evidence) that anything is wrong and even an emphasis that all is extremely well.
- Acceptance or resignation to their situation as being part of being old/disabled/vulnerable.
- Depression, withdrawal from activity or communication, fearfulness.
- Dramatic changes in behaviour or personality
- Physical or verbal outbursts or displays of anger, often out of character
- Seeking help/attention from many sources, maybe inappropriately or frequently.

6.9. It is quoted that victims of domestic violence will have suffered more than thirty five incidents before they are prepared to report the abuse. Staff need to be aware that the fear of unknown intervention can feel more risky than the known fear of abuse for some vulnerable people. Denial that there is a problem may be an expected response in even very serious cases.

6.10. The following pages provide a guide to the various types of abuse, giving examples and possible indicators. The presence of any of these signs does not establish abuse or neglect, but should alert people to the possibility that it may exist. It should also be stressed that abuse may be occurring even though none of these possible indicators are present.

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<p>6.8 Physical Abuse is the use of force which results in pain or injury or a change in the person's natural physical state</p>	
<p>Examples:</p> <p>Punching Slapping Hitting Shaking Pinching Burning/scalding Enforced sedation Forced feeding The use of excessive restraint Catheterisation for ease of "management"</p>	<p>Possible Indicators:</p> <p>Black eyes Welt marks Fractures Sprains Dislocations Drowsiness Lacerations Pressure sores Unexplained injuries Scalds/cigarette burns Bruises (especially in well protected areas) Confusion due to over sedation Delays in seeking medical attention Anxiety or fear more evident in the presence of a possible abuser</p>
<p>6.9 Sexual Abuse is the involvement of a vulnerable adult in sexual activities or relationships which</p> <p>i. They do not want and have not consented to; or</p> <p>ii. They cannot understand and are not able to consent to</p> <p>(Please see Appendix 1 for further guidance on consent)</p> <p>Every person has a right to engage in sexual activities that are lawful and wanted and understood without being exposed to exploitation or sexual violence</p> <p>Sexual activity between employed staff and a vulnerable adult is never acceptable and will always be regarded as sexual abuse</p>	
<p>Examples:</p> <p>Enforced sexual contact Harassment Serious teasing or innuendo Sex for reward Pornographic photography Enforced witnessing of sexual acts or sexual media Penetration or attempted penetration of vagina, anus, mouth, with or by penis, fingers, other objects</p>	<p>Possible Indicators:</p> <p>Changes in behaviour (e.g. more withdrawn, depressed, confused, fearful, agitated) Difficulty in walking or sitting Torn, bloody or stained underclothes Pain or itching in the genital area Bruising or bleeding in external genitalia, vaginal or anal areas Venereal disease Sexualised behaviour</p>

<p>6.10 Psychological Abuse is behaviour that has a harmful effect on a vulnerable adult's emotional health and development</p>	
<p>Examples:</p> <p>Absence of warm support or human contact</p> <p>Swearing Insults</p> <p>Humiliation Shouting</p> <p>Threats Intimidation</p> <p>Ignoring Racist abuse</p> <p>Lack of stimulation</p> <p>Enforced isolation</p> <p>Confining or locking someone in</p> <p>Depriving an individual of the right to choice, information and privacy, respect</p> <p>Preventing access of other people in the home</p>	<p>Possible Indicators:</p> <p>Fear Passivity</p> <p>Confusion Wandering</p> <p>Depression Withdrawal</p> <p>Running away</p> <p>Mental anguish/anxiety</p> <p>Loss of independence</p> <p>Low self-esteem</p> <p>Behaviour which is out of character</p> <p>Uncontrolled/unprovoked crying</p> <p>Unusual weight loss or gain</p> <p>A lock on the outside of room</p> <p>Disturbed sleep pattern</p> <p>A physical environment that does not allow access to other parts of the home</p>
<p>6.11 Financial & Material Abuse is the use of a vulnerable person's property, assets, income without their informed consent or making financial transactions which they do not comprehend (unless this is legally sanctioned)</p>	
<p>Examples:</p> <p>Deprivation of money/benefit</p> <p>Taking possessions</p> <p>Fraud, Stealing or misappropriating money</p> <p>Using pressure to obtain rights to property or to give money away, including in Wills</p> <p>Financial transaction between staff and service user without explicit written consent of a service manager</p> <p>Inducing a person to pay for goods or services from or on behalf of the recipient where this is not a reasonable expectation or where the sums paid would be considered excessive</p>	<p>Possible Indicators:</p> <p>A "disappearing" pension</p> <p>Homelessness Hypothermia</p> <p>Malnutrition Inadequate clothing</p> <p>Insufficient money to purchase basic necessities</p> <p>Inadequate money to pay bills etc</p> <p>Inadequate heating/lighting</p> <p>Sudden and/or large withdrawal from bank etc</p> <p>Legal documents requiring signature</p>

6.12 Institutional Abuse is the regimentation of residents/users of a service	
<p>Examples: (also see above categories)</p> <p>Undue restraint due to staff shortages (low seated chairs, cot sides, harness, use of sedatives / other drugs, withholding drugs, etc.</p> <p>Lack of choice about bed times, meals etc.</p> <p>Lack of respect for a person's environment such as smoking in a person's home, or playing music/watching TV that reflects staff interest rather than that of the service user</p> <p>Denial of privacy such as absence of screens, leaving toilet doors open etc.</p> <p>Lack of supervision resulting in intentional/accidental harm, poor safety, pressure sores</p> <p>Lack of stimulus or recreational activity</p> <p>Lack of consideration of a person's language, cultural or dietary needs</p> <p>Punishment for perceived "bad" behaviour</p> <p>Lack of promised care</p> <p>Personal possessions or money used for someone else</p>	<p>Possible Indicators:</p> <p>Poor management of life in the living environment</p> <p>Poor standards of cleanliness</p> <p>Low staffing levels over a long period of time</p> <p>Low staff morale High staff turnover</p> <p>Lack of knowledge about care guidelines; staff factions:</p> <p>Lack of positive communication with residents</p> <p>Punitive treatment of residents/patients</p> <p>Staff ordering residents around</p> <p>Low level/absence of staff training</p>
6.13 Discriminatory Abuse is slurs or similar treatment that is based upon a person's race, gender, sexual orientation, disability, age, religious or other beliefs and other forms of harassment	
<p>Examples:</p> <p>Isolation from religious or cultural activities or antipathy to a religion or cultural activity</p> <p>Racial harassment</p> <p>Refusal to accept support from services</p> <p>Remarks or actions or being treated unfairly because of a person's disability or sexual orientation.</p>	<p>Possible Indicators:</p> <p>Unable to eat culturally acceptable foods</p> <p>Religious observances not encouraged or anticipated</p> <p>Isolation due to language barrier</p>
6.14 Neglect And Acts Of Omission is behaviour which results in the vulnerable person's basic needs not being met	
<p>Examples:</p> <p>Failure to provide adequate health care</p> <p>Failure to provide adequate food/drink</p> <p>Failure to provide a safe and adequately heated environment,</p> <p>Failure to assist with appropriate levels of</p>	<p>Possible Indicators:</p> <p>Dehydration Malnutrition</p> <p>Infections Hypothermia</p> <p>Inadequate clothing</p> <p>Pressure sores</p> <p>Unexplained failure to respond to prescribed</p>

hygiene	medication
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7. Patterns of Abuse/Abusing

- 7.1 Patterns of abuse and abusing vary and reflect different dynamics. These include:
- Serial abusing in which the perpetrator seeks out and grooms vulnerable individuals. Sexual abuse usually falls into this pattern, as do some forms of financial abuse.
 - Long-term abuse in the context of an ongoing family relationship such as domestic violence between spouses and generations.
 - Opportunistic abuse such as theft occurring because money has been left around.
 - Situational abuse, which arises because pressures have built up and/or because of difficult and challenging behaviour.
 - Neglect of a person's needs because those around him or her are not able to be responsible for their care, for example if the carer has difficulties attributable to such issues as debt, alcohol or mental health problems.
 - Institutional abuse which features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing, and an insufficient knowledge base within the service.
 - Unacceptable treatments or programmes which include sanctions or punishments such as withholding food and drink, seclusion, unnecessary and unauthorised use of control and restraint or over-medication.
 - Failure of agencies to ensure staff receive appropriate guidance on anti-racist and anti discriminatory practice.
 - Failure to access key services such as health care, dentistry and prostheses.
 - Misappropriation of benefits and/or use of the person's money by other members of the household.
 - Fraud or intimidation in connection with wills, property or other assets.

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C. Basic Procedure

8. Key Principles

- 8.1 The purpose of any safeguarding adults investigation is to achieve a good outcome for vulnerable adult concerned.
- 8.2 At all times the best interests of the victim should be at the centre of the safeguarding process and the guiding principal for any actions taken.
- 8.3 There are seven basic stages in the safeguarding adults procedure. These are summarised on the next page. Each stage is then outlined in [subsections 9-16](#).
- 8.4 Before referring a case to either social services or the police, in most cases the consent of the vulnerable adult should be sought. Please see [section 17](#) for further details.
- 8.5 At all stages, the vulnerable adult and their carer/representative/advocate must be treated as an equal partner in the safeguarding process. This includes consulting with them at all stages of the process. The only exception to this is where it is in the best interests of the vulnerable adult concerned not to involve them the process. For example, for their own safety or to avoid contamination of evidence. Where this is the case, the reason for this decision must be clearly recorded.
- 8.6 If, at any stage, the vulnerable adult requires immediate protection this must be given.
- 8.7 If, at any stage, a suspicion of abuse/neglect of a child becomes apparent Children's Social Services should be contacted immediately.
- 8.8 Alleged abusers should not be contacted until there is an agreed safeguarding assessment strategy, unless this is necessary in an emergency situation.
- 8.9 If, at any stage, it appears a crime has been committed, the police should be contacted. A police investigation must take precedence over any other lines of enquiry or internal processes. However, the vulnerable adult should still be given appropriate support.
- 8.10 The nature of a safeguarding issue may change at any stage. For example, new evidence may emerge which indicates that the case is not appropriate for a safeguarding investigation but may be dealt with through other means, such as amending the person's care plan.
- 8.11 If, at any stage, a decision is taken that the case is not appropriate for a safeguarding adults investigation, the reasons for this must be clearly recorded.
- 8.12 At all stages in the procedure, all information potentially relevant to an investigation must be recorded contemporaneously.
- 8.13 The timescales given must be complied with. The only exception to this is where it is in the best interests of the vulnerable adult concerned to delay the process. Where this is the case, the reason for the delay must be clearly recorded. The timescales refer to 'working days'.

Summary of Procedure for Safeguarding Vulnerable Adults	
<i>Stage 1. Alert</i>	<i>Day One</i>
Someone alerts a worker in a partner organisation to a suspicion of abuse. Worker immediately informs contact point in own organisation.	
<i>Stage 2. Referral</i>	<i>Day One</i>
Alert is referred to Adult Social Services, ILDP or mental health team. Member of team receiving allegation immediately reports it to Safeguarding Adults Manager (SAM). SAM advises team member what initial information needs to be gathered.	
<i>Stage 3. Decision</i>	<i>Day Two</i>
Team member reports initial information gathered to SAM. SAM decides whether safeguarding process or other is appropriate.	
<i>Stage 4. Strategy</i>	<i>Day Five</i>
SAM coordinates strategy discussions and/or meetings with appropriate people. A strategy for investigating the abuse/assessing the risk to the vulnerable adult is jointly agreed (see template in Appendix 4).	
<i>Stage 5. Investigation</i>	<i>Four weeks from Referral</i>
Investigation completed according to the strategy. SAM decides whether case conference/safeguarding plan is appropriate.	
<i>Stage 6. Case Conference/Plan</i>	<i>Four weeks from Investigation/Assessment</i>
Case conference is held and safeguarding plan agreed (see template in Appendix 5).	
<i>Stage 7. Review</i>	<i>Six months of Plan</i>
Safeguarding plan is reviewed.	

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9. Stage 1. Alert

(Day One)

- 9.1 Any immediate protection needs must be met. '999' should be called immediately in any emergency situation – for example, if there is a medical emergency or if it is clear a crime has been committed.
- 9.2 Otherwise or in addition, a safeguarding alert should be made; however, this action may be prevented by the person refusing their consent for information to be passed to another organisation. Please see [sections 17 and 18](#) for more information.
- 9.3 Any one (relative or friend, staff member, member of the public, or the vulnerable person themselves) can raise an alert if they have concerns that a vulnerable adult is at risk of abuse. Details of who to contact are given in [Appendix 11](#).
- 9.4 Guidance for staff on how to respond to disclosure of abuse from vulnerable adults is given in [Section 26](#).
- 9.5 All staff may come across allegations/suspicions of abuse in a variety of ways and settings and in some instances evidence may accumulate over a period of time.
- 9.6 Staff must treat seriously all allegations/suspicions of abuse involving a vulnerable adult and report these to their line manager. If it is difficult for a member of staff to tell their line manager, or the line manager is the suspected perpetrator, then a more senior manager should be contacted. Otherwise, the Adult Social Services Access Team should be contacted (see [Appendix 11](#) for details).

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10. Stage 2. Referral

(Day One)

- 10.1 Line manager (or other contact point) should refer the alert immediately to the relevant social care team (Adult Social Services, ILDP or mental health).
- 10.2 The referral can be re-allocated as appropriate by the social services team receiving it.
- 10.3 Registered residential care homes have a legal obligation to notify the Care Quality Commission under Regulation 37 of the Care Homes Regulations (see [Appendix 1](#) for details).
- 10.4 The team receiving information about the alleged/suspected abuse should ask as much information as possible. If requested, a member of the public can give an alert anonymously. The team member should then record details of the alert and discuss it immediately with their team manager.
- 10.5 The team manager should instruct the team member to gather initial information, including:
 - the vulnerable adult's own wishes (or views of their representative/advocate)
 - what is known about the vulnerable adult's capacity to give consent
 - whether a disclosure has been made by the vulnerable adult

- the type/seriousness of alleged/suspected abuse
- the needs of the vulnerable adult and suspected/alleged perpetrator

- whether the adult comes under the definition of vulnerable adult (see [Section 2](#))
- what is known of the vulnerable adult's ability to communicate
- nature of relationship between the alleged perpetrator and the vulnerable adult
- any relevant history

10.6 The only exception to this being where collecting such information would put the vulnerable adult at further risk.

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11. Stage 3. Decision

(By Day Two)

- 11.1 The team member reports back to the team manager their findings.
- 11.2 The team manager decides whether or not safeguarding adults procedures are appropriate.
- 11.3 If not, the reason for this must be clearly recorded on the AP3 form. This section of the AP3 form must then be countersigned by a Service Manager.
- 11.4 If the team manager decides to continue with the safeguarding adults procedure, s/he must coordinate strategy meetings/discussions.
- 11.5 At this stage, the referrer must be informed of the outcome of the referral.

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12. Stage 4. Strategy

(By Day Five)

- 12.1 The purpose of strategy meetings and/or discussions is to share information, assess risk and agree an investigation strategy.
- 12.2 An investigation strategy is likely to involve investigation into different lines of enquiry at the same time.
- 12.3 The 'Strategy Meeting' template ([appendix 4](#)) sets out the different areas of strategy discussion that need to be held.
- 12.4 The Safeguarding Adults Manager (SAM) and/or team member should meet or discuss with all other relevant people to agree the strategy.
- 12.5 Emails, telephone, letter, face-to-face conversations and meetings are all appropriate ways of discussing the strategy.
- 12.6 Depending on the nature of the case, various people will need to be involved in the strategy.
- 12.7 Where appropriate, the vulnerable adult (or their representative or advocate) should give their consent to the investigation ([see section 17](#)).

- 12.8 Where a crime has been committed, the police should already have been contacted. The purpose of the strategy meeting/discussion may be to agree with the police how social services might be involved in the police investigation.
- 12.9 Where a commissioned provider service is implicated, the appropriate regulatory body and commissioner will need to be consulted.
- 12.10 Where more than one vulnerable adult in a commissioned provider service is implicated, the 'Establishment Concerns' policy may need to be followed (see [Appendix 14](#) for further information).
- 12.11 The decision how to involve a provider (either Council provided or contracted) will need to be taken with care. Where the alleged abuse relates to a single member of staff, and a disciplinary investigation is seen as appropriate, the manager or proprietor of the service may be appointed by the SAM of the case to undertake the investigation. However, where there is evidence the suspected abuse may relate to wider organisational weaknesses, it may be more appropriate for someone outside of that organisation to undertake the investigation, or parts of the investigation.
- 12.12 Only in extreme circumstances, where it is clearly in the best interests of the vulnerable adult concerned, should the alleged abuser be involved in the strategy discussions. Reasons for this must be clearly recorded. The vulnerable adult (or representative or advocate) must give their consent beforehand.
- 12.13 By the end of the strategy meetings/discussions, an appropriate 'Safeguarding Adults Manager' (SAM) and a 'Safeguarding Adults Investigation Officer (SAIO) should be appointed. The SAIO can be a member of staff from any organisation, as long as they are appropriate.
- 12.14 It is the responsibility of the SAM to coordinate the investigation/assessment.
- 12.15 The SAIO is responsible for carrying out the investigation/assessment. S/he is also responsible for making sure that all details of the investigation are recorded correctly.
- 12.16 All details of these strategy discussions/meetings should be recorded using the template (see [Appendix 4](#)).
- 12.17 Actions agreed in the meeting/discussion should be sent out to all concerned by the end of the following day.
- 12.18 The full record of the strategy meetings/discussions must be sent out to all those involved no later than ten working days after they have been held.

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13. Stage 5. Investigation

(Within four weeks of the alert)

- 13.1 Investigation is undertaken according to the strategy.
- 13.2 Evidence may emerge which requires adjustment to the original strategy. This should

be agreed with all relevant individuals/parties and recorded.

- 13.3 If the strategy includes interviewing the vulnerable adult, see [Sections 20](#) and [27](#) for further information.

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14. Stage 6. Case Conference/Protection Plan

(Four weeks after completion of investigation)

- 14.1 The investigation should be completed by the SAIO. The SAIO should recommend whether the allegation or suspicion of abuse should be substantiated, partly substantiated or unsubstantiated.
- 14.2 In many cases, the SAM, in consultation with all appropriate individuals/parties, will decide to hold a 'case conference' to consider the findings of the investigation and decide whether the allegation or suspicion of abuse should be substantiated, partly substantiated or unsubstantiated.
- 14.3 In many cases, the SAM, in consultation with all appropriate individuals/parties, will decide to include an element of 'protection planning' in the case conference – but the two may be kept separate where appropriate.
- 14.4 All such meetings – case conference, combined case and protection plan meeting and a protection plan meeting – should be recorded using the 'safeguarding meeting' template in [Appendix 5](#).
- 14.5 Everything should be done to facilitate the attendance of the vulnerable adult (and/or their representative or advocate). For example, numbers should be kept low and all access issues handled before the meeting.
- 14.6 Before the meeting, the vulnerable adult (and/or their representative/advocate) should be informed:
- Exactly what the meeting is about
 - Who will be at the meeting
 - What will be discussed - the agenda
 - They have a right to speak
 - They can sit where they choose
 - They can have a break at any time
 - They can have support and legal advice
 - They can bring an advocate
 - They can send an advocate on their behalf if they do not want to attend the meeting
- 14.7 The meeting should be chaired according to the template in [Appendix 5](#).
- 14.8 There should be a designated minute taker, who takes minutes in line with the template in [Appendix 5](#).
- 14.9 If it is decided not to include the vulnerable adult, the reason for this must be clearly recorded in the minutes. The reason must always be in the best interest of the

vulnerable adult.

- 14.10 Where the vulnerable adult (and/or their representative/advocate) does not attend, they must be informed of the outcome within ten working days.
- 14.11 Actions agreed in the meeting/discussion should be sent out to all concerned by the end of the following day.
- 14.12 The full record of the meeting must be sent out to all those involved no later than ten working days after they have been held.
- 14.13 The person/s who originally raised the alert must also be informed of the outcome of the case within ten working days of the meeting.
- 14.14 Any questions or clarification about the content of the minutes must be made to the Chair within five working days. Only the Chair can agree any changes to the content of the minutes.
- 14.15 The minutes of the case conference are confidential and should only be distributed to those agency members who attended or were invited to attend the meeting. They must *not* be reproduced without permission of the Chair.

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15. Stage 7. Review

(Six months of protection planning meeting)

- 15.1 Meetings to review the safeguarding plan should be held until those attending are confident the person can remain safe without them.
- 15.2 Review meetings should be organised in the same way as case conferences.

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16. Roles of Different Partner Organisations & Individuals

“Provider organisations” refers to all agencies which provide services to adults who are vulnerable whether in their home or in a residential setting. The term includes statutory, voluntary, independent sector organisations and faith groups.

- 16.1 Provider Staff Member
 - Take any emergency actions (police or medical)
 - Discuss the situation with their line manager
 - Participate in any meetings as requested
- 16.2 Provider Line Manager
 - Send an alert to relevant social services and notify CQC if vulnerable person states, or there is reason to believe, they may have been exposed to harm
 - As requested by the SAM, participate in strategy meetings/discussions.
 - As agreed in the investigation strategy, undertake parts of the investigation and feed these back to the SAM.

- Participate in case conference/protection planning meeting as required by the SAM.
- Co-operate if appropriate with drawing up and implementing the Protection Plan to minimise future risks to the vulnerable people in their care.

16.3 Safeguarding Adults Manager

- Ensure Safeguarding process is conducted within required time standards, and reasons for any delays are clearly recorded and authorised.
- Determine in consultation with others the strategy to an alert and to consult with key participants
- Appoint a Safeguarding Adults Investigation Officer
- Decide whether a safeguarding adults investigation is appropriate. If not, refer the issue on as appropriate. For example, it may be more appropriate for the issue to dealt with in the adult's care plan.
- Decide if a police investigation is to be sought
- Ensure support measures are in place for the alleged victim and that their views and wishes are reflected in the safeguarding
- Supervise Safeguarding Adults Investigation Officer throughout the investigation
- Monitor actions and decisions. Make sure these are recorded.
- Chair safeguarding adults meetings, clarify who will need to be invited, and ensure if the service is contracted that LBI/NHSI Strategy & Commissioning units are aware of the allegation/investigation
- Ensure that a Protection Plan is in place if required and formally reviewed
- Ensure all safeguarding documentation is completed within time standards.
- Take responsibility for ensuring that, where appropriate, the investigation is concluded on the grounds of probability, and in the best interests of the individual.

16.4 Team Member / Safeguarding Adults Investigation Officer

- Interview the vulnerable adults where possible and appropriate. Where not possible or appropriate, interview the vulnerable adult's representative/advocate.
- Establish facts and circumstances of the allegation including undertaking a risk assessment
- Record all details of the case.
- Make sure minutes of meetings, using templates in [Appendix 4](#) and [Appendix 5](#), are sent to relevant individuals/parties within time standards.
- Produce an Investigation Report using the template in [Appendix 6](#).
- Liaise with vulnerable person or their representative/advocate, provider and other participating agencies as required.
- Inform the original referrer of the outcome of the case.

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D. Further Procedural Detail

17. Consent and Capacity

- 17.1 Every vulnerable adult has the right to refuse referral, information sharing with another agency and safeguarding action (including investigation), with some exceptions.
- 17.2 Any member of staff must report suspected abuse to a manager, even if the adult has refused their consent. The manager will then take the decision whether or not the exceptions below apply.
- 17.3 The exceptions to this are:
- Where a person is assessed as not having the 'mental capacity' to make this decision and refuses their consent, appropriate representatives/advocates should be consulted. However, in such cases it is the final decision of the manager and/or statutory authorities involved.
 - Where a crime has taken place and there is an over-riding public duty for the police to investigate
 - Where other vulnerable adults and/or children may be at harm from the Person/Group/Agency suspected of causing abuse
 - Where gaining the adult's consent would place them at further risk
 - Where the adult is at serious risk of harm – this decision should only be taken with multi-agency agreement that this is in the adult's best interests.
- 17.4 In all other cases, the vulnerable person has the right to refuse safeguarding action and investigation. However, they should be counselled about this decision and ensure they have an opportunity to consider the implications of their decision.
- 17.5 If the vulnerable adult insists on refusing safeguarding action a risk assessment should record the consequent risks and the agreed plan, involving the vulnerable person and their carers/representatives as appropriate. The vulnerable adult must not be intimidated in anyway and must be informed that at any time they can change their mind.
- 17.6 In every case the wishes of the service user and their representative/advocate must be recorded.

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18. Confidentiality & Information Sharing

- 18.1 Currently there is no information sharing protocol across all partner agencies, although there are specific agreements (for example, between Housing & Adult Social Services and NHS Islington). The guiding principal is that in any request to share information, the interests and welfare of the vulnerable adult must be paramount.
- 18.2 To trust a professional worker with private and personal information is a significant matter. A person has the right to believe that such information given in confidence will not be released to others without their consent.
- 18.3 As a general principle, the worker must obtain the consent of the individual to the sharing of information. If an IMCA is appointed they have a statutory duty to examine and copy any relevant or potentially relevant documents ([see Appendix 1](#)).

- 18.4 Where the individual is not able to give informed consent, then the way in which this judgement was made, and the evidence for it, must be clearly noted, and the implications considered.
- 18.5 There is a responsibility for all workers to share information on a "need to know" basis where they judge that the best interests of an individual are likely to be served. All workers, therefore, have a clear duty to report suspected abuse to their line manager. The deliberate withholding of information cannot be defended on the grounds of confidentiality as non-disclosure may impact on the future safety and security of the individual and others. The most recent discussion of all aspects of patient identifiable information and how this is to be protected is to be found in the report of the Caldicott Committee *Report on the review of patient identifiable information*. That report recognises that confidential patient information may need to be disclosed in the best interests of the patient and discusses in what circumstances this may be appropriate and what safeguards need to be observed. The principles can be summarised as:
- Information will only be shared on a need to know basis when it is in the best interests of the service user;
 - Confidentiality will not be confused with secrecy;
 - Informed consent should be obtained but, it may be necessary to override the requirement; and
 - It is inappropriate for agencies to give assurance of absolute confidentiality where there are concerns about abuse, particularly in those situations when other vulnerable people may be at risk.
 - Where information, or a referral, comes from a third party who wishes to remain anonymous, or wishes for their identity to remain confidential, that wish is to be respected. However, every effort should be made to encourage referrers to identify themselves so that they can be contacted, as necessary, as the investigation progresses. This is particularly important if the referrer is providing evidence relating to a possible, or alleged, crime.
 - Each agency is bound by its own regulations on confidentiality of client information, and any doubts should be discussed with the Caldicott Guardian for the organisation. Any differences in approach need to be openly acknowledged, and take into account, where multi agency work is taking place.
- 18.6 Principles of confidentiality designed to safeguard and promote the interests of service users and patients should not be confused with those designed to protect the management interests of the organisation. These have a legitimate role but must never be allowed to conflict with the interests of service users and patients. If it appears to an employer or person in a similar role that such confidentiality rules may be operating against the interests of vulnerable adults then a duty arises to make a full disclosure in the public interests. See *Policy on Whistle-blowing* ([Appendix 7](#)). In certain circumstances it will be necessary to exchange or disclose personal information, which will need to be in accordance with the Data Protection Act 1998 where it applies. The Home Office and the Office of Data Protection Commissioner (formerly registrar) have issued general guidance on the preparation and use of protocols.

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19. Local & Inter-Borough Responsibility

- 19.1 Islington Adult Social Services have responsibility for co-ordinating the

investigation/assessment for people "ordinarily resident" in the Borough of Islington. Contact details are listed in [Appendix 8](#).

- 19.2 On occasions, allegations or concerns will be raised concerning abuse of a vulnerable adult living in a residential or nursing home placement outside the Borough, but where Islington was the placing authority. This can also occur where a person who normally resides in Islington is admitted to a hospital outside the Borough. The Association of Directors of Adult Social Services (ADASS) procedures maintain that the local authority in which the hospital or residential/nursing home resides should take overall responsibility for the co-ordination of the adult protection arrangements ([Appendix 3](#)). This protocol clarifies the roles of the Host authority and the placing authority.
- 19.3 The team receiving the referral should determine whether the vulnerable adult concerned is 'ordinarily resident' in the Borough. If s/he is not, then the team should satisfy itself that the responsible Local Authority Social Services in that region is prepared to take responsibility for the co-ordination of the investigation, and ensure that all relevant information is passed over to that region. Line Managers at the appropriate levels must resolve any dispute about responsibility for individuals.

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20. Interviewing the Alleged Victim (see also [Section 27](#))

- 20.1 In most cases, the vulnerable adult should be interviewed.
- 20.2 Every effort must be made to keep to a minimum the number of times an alleged victim is interviewed about a specific incident (See [Section 27](#) for guidance on interviewing vulnerable adults). If an Independent Mental Capacity Advocate (IMCA) is involved it may be wise to co-ordinate with them, and in some cases a joint interview
- 20.3 Where a criminal offence appears to have been committed and the vulnerable adult has given their consent to contacting the police, the Safeguarding Adults Investigation Officer should ask for police advice before arranging an interview.
- 20.4 Where the SAM decides the police do not need to be involved, they should decide when, or if, it is appropriate to interview the vulnerable adult and instruct the SAIO accordingly.
- 20.5 Normally two people should be involved in interviewing the alleged victim.
- 20.6 The Safeguarding Adults Investigation Officer will normally be directly involved in interviewing the alleged victim. Careful consideration needs to be given to who else should be involved in the interview (e.g. key workers in residential and day care settings, other professionals in regular contact with the person, carers, relatives, trusted friends or where appropriate, an advocate) and where it should take place.
- 20.7 Great care should be taken not to disclose the content of the allegation in the interview but to facilitate the interviewee to explain the purpose or keep the explanation very general, to avoid being seen as offering leading questions.

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21. Medical Treatment/Examination

- 21.1 In cases of physical abuse, it may be unclear whether injuries have been caused by abuse or accidentally. Those pursuing referrals need to consider carefully whether explanations are consistent with sustained injuries, and take medical/specialist advice as appropriate.
- 21.2 If medical treatment is required, an immediate referral to the person's GP, Accident & Emergency Department or the relevant specialist health team should be made. If emergency medical treatment is necessary, this should be sought immediately by the person first coming into contact with the vulnerable adult concerned.
- 21.3 If forensic evidence needs to be collected, the police should always be contacted and they will normally arrange for a police surgeon to be involved. Some difficulties may arise here if the person is not able to give their own consent to being examined by the police and these issues will need to be discussed with the police as quickly as possible. If a person is unable to give consent for a medical examination, careful consideration should be given as to whether an intrusive medical examination is in the vulnerable person's best interests or whether it could be construed by them as abusive. This decision could involve the services of an IMCA.
- 21.4 Every effort should be made to ensure that there need only be one medical examination. The Safeguarding Adults Investigation Officer should make certain that the person is properly supported throughout the medical examination.
- 21.5 The Safeguarding Adults Investigation Officer should offer to counsel the person who has been abused regarding their decision and its implications. In some situations it may be appropriate to engage the help of appropriate representatives/advocates to advise and assess the alleged victim.
- 21.6 In cases where an individual is unable to give informed consent, doctors can proceed to examine and/or treat on the basis that they are 'acting in good faith' in view of their 'duty of care'. In these circumstances the views of the vulnerable persons' relatives or other significant people should be sought wherever possible and appropriate on medical or surgical intervention.
- 21.7 The views of relatives or other people close to the patient may help the medical team assess what is in the patient's best interest by clarifying what the patient would have wanted but they have no particular legal standing. It is therefore unnecessary to ask relatives to sign consent forms on behalf of incapacitated patients.
- 21.8 If a vulnerable person needs to be admitted to hospital in order to receive any medical treatment required, discharge should not occur until satisfactory arrangements have been made to ensure that the person will be safe.

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22. Police Involvement

- 22.1 Where there appears to be evidence of a crime having been committed against a person or property, the police should normally be informed. The vulnerable adult needs to give informed consent to this action, though in cases where the withholding of

consent would put other service users at risk, the police would always need to be contacted. The CSU police can be contacted for advice if there is any uncertainty, but rarely take any action in cases where they have not recorded a police report.

- 22.2 Where informed consent is not given, the implications of this should be explained to the vulnerable adult by the Safeguarding Adults Investigation Officer and a risk assessment considered to minimise the likelihood of re-occurrence. If the vulnerable adult is not in a position to give or refuse consent, this may in turn mean consideration of whether they have capacity and, if not, whether it is in their best interests to report the offence to the police. This maybe particularly relevant in cases where serial offences are likely.
- 22.3 Where someone is unable to give her/his informed consent to police involvement, the views of the person's immediate carer (unless s/he is the alleged perpetrator) will need to be taken into account. Where there is nobody to advocate for a person who is unable to give their informed consent, the Safeguarding Adults Investigation Officer should make the decision whether to contact the police, in consultation with the Safeguarding Adults Manager.
- 22.4 Where a criminal offence appears to have been committed, a police investigation would normally be initiated at this stage, involving interviewing the alleged victim, the alleged perpetrator and witnesses, if any. The investigation should be conducted in consultation with the Safeguarding Adults Investigation Officer.

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23. Where the Alleged Perpetrator is also a Vulnerable Person

- 23.1 In this situation, the protection of the person alleged to have been abused remains paramount. Consideration must be made as to whether the alleged victim and the alleged perpetrator have the mental capacity to make decisions regarding the incident. (See [Appendix 1](#) for guidance under Mental Capacity legislation).
- 23.2 The situation of the alleged perpetrator also requires detailed and careful consideration, including:
- the extent to which she/he is able to understand her/his actions
 - the extent to which the abuse reflected that individual's own needs and situation
 - the likelihood of the alleged perpetrator further abusing the victim or other service users
- 23.3 In many cases it may be necessary to hold a separate meeting to consider the needs of the alleged perpetrator. Sometimes difficult decisions will need to be made, when the needs of the alleged perpetrator conflict with those of the alleged victim and/or potential victim.
- 23.4 A decision will need to be taken as to whether the alleged perpetrator's family (or other people significant in their lives) are told about the incident. This is particularly relevant in relation to those people whom the alleged perpetrator lives with, or with whom s/he is in regular contact.
- 23.5 It may be appropriate for the line manager of the Safeguarding Adults Manager, or a Safeguarding Manager from a different team, to chair safeguarding meetings where there is potentially a conflict between the needs of an alleged perpetrator and an

alleged victim (e.g. where they both live in the same residential placement or attend the same day centre) and/or the two vulnerable people are the responsibility of two different care management teams. The main objective must, however, be to protect the vulnerable person from abuse, and the decision of safeguarding meeting should reflect this.

- 23.6 In these cases, there will need to be very careful discussion between the Safeguarding Adults Investigation Officer in relation to the role of the police in the investigation/assessment where an offence appears to have been committed. If the vulnerable person is to be the subject of police proceedings then an "appropriate adult" under the PACE procedures and a legal representative must be found. It is a Police responsibility to find an appropriate adult and legal representation in these circumstances. Where the alleged perpetrator is mentally disordered, an Approved Social Worker/Approved Mental Health Practitioner (ASW/AMHP) should be consulted.

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24. Where the Alleged Perpetrator is a Member of Staff

- 24.1 All suspicions or allegations of abuse of a vulnerable adult by a member of health or care staff should be reported as a safeguarding alert to social services trained staff or, where appropriate, the police. The health or care organisation should not investigate the abuse or interview the vulnerable adult; either the social services team or the police will take the lead in the investigation. However, the organisation's lead officer should decide whether disciplinary procedures are necessary to be put in place. If so, the organisation's lead officer should discuss this with the SAM.
- 24.2 The SAM should decide whether it is appropriate to investigate the issue using the safeguarding adults procedure, or whether a health or care organisation's own disciplinary procedures are appropriate.
- 24.3 Where the alleged perpetrator works in a registered residential care home or nursing home, the home should notify CQC.
- 24.4 If the SAM decides that the safeguarding adults procedure is appropriate, then the appropriate social services trained team will lead the investigation. In the course of strategy meetings/discussions, it may be decided that the health or care organisation should undertake parts of the investigation. The SAM would continue to have lead responsibility for the case.
- 24.5 The Safeguarding Adults Investigation Officer should discuss the investigation of the allegation or suspicion of abuse with a senior manager from the employer agency, CQC and the commissioning office, following the strategy meetings/discussions.
- 24.6 If there is thought to be the potential for widespread abuse to residents or by more than one staff member the Safeguarding Adults Development Manager should be contacted, to consider whether the Establishment Concerns procedure should be followed (see [Appendix 14](#)).
- 24.7 Discussion about disciplinary action in relation to the member of staff concerned is the prerogative of the employing agency. The appropriate senior manager in the employing agency should decide as a matter of urgency whether to suspend the alleged

perpetrator in order to allow the investigation to proceed unhindered. In the case of staff employed by an approved domiciliary care employer, however, the Safeguarding Adults Manager may direct that the member of staff is taken off all Council purchased work, even if s/he has not been suspended by the employer. Such a decision will be made in line with guidance provided by the Council's own disciplinary code.

- 24.8 When the disciplinary code is invoked, an officer from the employer should immediately be appointed by that agency. This officer should link with the Safeguarding Adults Investigation Officer and the police, if they are involved, over the conduct and direction of the investigation of the allegations and the protection plan for the vulnerable adult. If there is a police investigation, this should normally be completed before the employer's investigating officer pursues her/his investigation in accordance with the disciplinary code (*see Performance Management Misconduct & Criminal Convictions procedure for LBI staff*), and agreement should be sought with the police as to the timing of the disciplinary investigation. However, it will not normally be necessary to await the outcome of a court case before instituting disciplinary action if sufficient evidence is available to come to a conclusion on the balance of probabilities
- 24.9 It will be necessary that the investigation identifies whether anyone else cared for by the alleged perpetrator is likely to have been abused by her/him.
- 24.10 Staff subject to disciplinary proceedings should be kept informed of the allegations and the overall progress of the investigation and will often require support, provision for which should be made by the employing agency. Also staff who have reported allegations/suspicions of abuse may need support.
- 24.11 Where there is a disciplinary hearing called to take a disciplinary decision, this should be adjudicated by a senior manager in the employing agency who has not been directly involved in the investigation of the allegations/suspicions of abuse.
- 24.12 The Safeguarding Adults Manager will take responsibility for promptly informing the relevant Commissioning Manager of events. The Commissioning Manager will ensure that statutory authorities responsible for the care of other individuals who may be affected are informed of concerns and/or investigations, and co-ordinate any further action required.
- 24.13 When the investigation is complete and indicates that a member of staff has been guilty of abuse, a referral should be made to ISA list and is the responsibility of the employer ([see Section 4.5](#)).
- 24.14 The flowchart below outlines the process to be followed where an allegation relates to a member of staff.

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Key steps in responding to abuse allegations involving a member of staff

Allegation or suspicion of abuse involving members of staff

Take emergency action if necessary and report to your line manager.

Police contacted immediately if crime is suspected

Line manager to consider immediate appropriate action for staff member under suspicion. Report concerns to social services team (& CQC if duty to do so) by phone or by sending the completed Alert form to a social services team.

Safeguarding Adults Manager considers:

- Does there appear to be substance to the allegation/suspicion of harm? **And**

On the information so far, is it possible that a member of staff has harmed the service user/vulnerable person?

'Yes' to either

Safeguarding adults procedures instigated.
 If the service user is deemed to have mental capacity to make decisions about the allegation, record their wishes about a possible investigation. If not, consideration should be made to engaging an IMCA.
 Measures to support alleged victim taken.

'No' to both

No further action under the adult protection procedure
 Where appropriate, a service user/advocate should be asked whether they wish to make a complaint under social service or provider procedures.

Provider makes decision whether (1) to initiate a disciplinary investigation **and** (2) to suspend member of staff. If deciding not to suspend, some risk limitation should be considered (for example, doubling up of staff members, or putting on duties without direct access to vulnerable people).

If there is a disciplinary investigation, the provider appoints an officer to lead this.

Are police involved?

'Yes'

Police take lead in investigation with SAIO and provider officer. Police consulted on timing of disciplinary hearing.

Police may forward papers to Crown Prosecution Service for them to decide whether there should be a prosecution

'No'

Investigation/assessment by SAIO and, where appointed, a provider officer asked to invoke disciplinary process (if not already happened)

Where disciplinary hearing called to take a disciplinary decision this is adjudicated by senior manager in employing agency

If abuse has taken place and a registered care/ nursing home or domiciliary service is involved, contact relevant CQC Officer or Contract Monitoring Manager should decide whether a review

in line with their inspection/monitoring role is necessary. In a situation of possibly serious or widespread abuse the Safeguarding Adults Development Manager should be contacted to consider Establishment Concern meeting.

If abuse by the staff member is proven, referral to the ISA list is required – [see Section 4.5](#)

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25. Where the Alleged/Suspected Abuse takes place in a provider organisation but does not concern a member of staff or volunteer

- 25.1 Where suspected/alleged abuse takes place in a provider organisation, but does not concern a member of staff or volunteer, the organisation should refer this to the relevant social services team.
- 25.2 In some cases the SAM may decide it is appropriate for the organisation's internal staff to undertake parts of the investigation and report back on the abuse that has taken place. This decision should be made by SAM, in consultation with others, during strategy meetings/discussions.
- 25.3 While a provider organisation can undertake parts of the investigation, the SAM must always be employed by a statutory organisation and have undertaken all levels of safeguarding adults training.

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E. Procedural Guidance

26. Responding to a disclosure

- 26.1 Phone 999 if an emergency for Police /Ambulance Service as appropriate
- 26.2 Listen carefully to what is being said and re assure the person that what they are saying will be taken seriously. Often an individual will feel that they will not be believed
- 26.3 Only ask questions sufficient to establish what has happened and if the adult or another is in immediate risk of harm. Ask only what you have to in order to establish the basic facts and no more.
- 26.4 Record factually what exactly the person said and make a note of that time, date and where they made the admission. If the comments are recorded in this way then there is a greater likelihood that the evidence will be allowed as evidence in court.
- 26.5 Do not make promises that might not be able to be keep regarding confidentiality? If there is evidence of a serious crime or other factors involved then it is your duty to share (see section on consent)
- 26.6 Take steps to preserve evidence where possible and explain this to police. It is equally important to explain if you have moved or touched something that might be relevant
- 26.7 Discuss with the adult who will be informed and offer support

- 26.8 Do not speak to the perpetrator first. This could place both yourself and others at risk and may compromise the investigation.

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27. Interviewing Vulnerable Adults (and their possible reactions)

27.2 This practice note gives some guidance on interviewing vulnerable adults and some of the common reactions to abuse. Interviewing is often a complex task requiring careful planning beforehand. In many cases a vulnerable person will have limited communication and understanding.

27.3 Points to note before interviewing:-

- Avoid reaching conclusions about the suspected abuse before the facts are known
- Consult with an IMCA if appointed.
- Ensure that any communication difficulties are recognised prior to the interview. (Please see [Appendix 8](#) for telephone numbers of interpreting service and sign language interpreter, speech and language therapists.)
- The location of the interview must ensure privacy, safety and lack of interruption
- Allow time, remain calm, unhurried and non-accusatory
- Be clear about confidentiality and explain that information will only be shared on a "need to know" basis explaining also what that means
- Be aware of making stereotypical judgements about race, gender sexuality and disability
- Informing the interviewee of purpose of interview - think beforehand about how you will explain why you are there. It is important not to alarm the interviewee and to establish rapport first. You may initially want to indicate general concern, rather than explain an allegation of abuse has been made
- Encourage the person to talk (free narrative). If you need specific information use open-ended questions (i.e. What? How?) without leading the person towards a particular response. This should invite more detailed, spontaneous responses.
- Take account of background information: family history and dynamics, assessment of level of dependency, assessment of needs of carers, what services are being provided, physical and material environment.
- When closing the interview, summarise what you understand they have said and invite them to ask you questions. Ensure that they are thanked for this, and you can recognise it may have been a difficult experience for them. Let them know what will happen next and who they can contact if concerned about something later on.

27.3 Victims of abuse do not always react in the same way. However, some of the more common reactions are as follows:

- Denial that anything is wrong and even an emphasis that all is extremely well
- Acceptance or resignation of their situation as part of being old and/or disabled
- Withdrawal from normal activities through a continuum to a total lack of communication
- Depression which can either happen very suddenly or gradually emerge

- A dramatic change of behaviour/personality: this can happen very suddenly and unexpectedly and is often associated with fear. This may indicate an attempt at self-protection
- Physical or verbal outbursts or displays of anger that are out of character
- Confusion: this can be characterised by a sudden onset or a marked deterioration in a previously confused person
- Seeking help from numerous sources/people. This may be a direct request for help or attention seeking behaviour.

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28. Mental Capacity: The Basic Principles

- 28.1 See also [Appendix 1](#) for an outline of the Mental Capacity legislation. In medical parlance, to have capacity to make a decision about treatment, individuals should be able to:
- Understand in broad terms and simple language what the medical treatment is, its purpose and nature and why it is being proposed now for them
 - Understand its principal benefits, risks and alternatives
 - Understand in broad terms what will be the consequences of not receiving the proposed treatment
 - Possess the capacity to make a free choice (i.e. Free from pressure)
 - Retain the information for long enough to make an effective decision.
 - These principles are transferable to any professional intervention.
- 28.2 It must be remembered that:
- There is a presumption of capacity until the contrary is demonstrated
 - Any assessment as to an individual's capacity has to be made in relation to a particular proposal
 - Capacity in an individual with a mental disorder can be variable over time
 - Capacity may be temporarily impaired due to toxic conditions or extreme illness
 - All assessments of an individual's capacity should be fully and appropriately recorded

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29. Guidance on Consent relating to Sexual Activity and Vulnerable Adults

- 29.1 Consent is the crucial issue in determining whether a particular act, relationship or situation is abusive of someone who is vulnerable.
- 29.2 The two pertinent questions are:
- Whether the vulnerable person did give her/his consent? **And**
 - Whether the person could give her/his consent?
- 29.3 Abuse occurs when:
- The vulnerable person withholds consent; or
 - The person is unable to give her/his consent because the severity of her/his learning disability/mental illness significantly undermines her/his understanding of the basic elements of sexual behaviour; and/or

- The individual is subject to a degree of pressure which prevents the individual making a free personal choice. If the person is unable to think "about" or "through" sexual behaviour in any of the following ways, then s/he is not in a position to consent to sexual activity:
 - Making sense of what has been done to her/him and/or construing the sequence of behaviours as a sexual act
 - Appreciating the appropriateness or inappropriateness of particular behaviour
 - Appreciating the value accorded to sexual acts
 - Appreciating the possible consequences of sexual acts

29.4 Even where a person is able to make such judgements, there may be other factors, which mitigate against freely given consent. They are:

- The presence of a parental or familial relationship between the persons involved (excluding husband and wife); this may involve the offence of incest
- The presence of a custodial or care-taking relationship between the persons involved; sexual activity between employed care staff and vulnerable adults should always be viewed as abusive
- The use of a weapon, threat of injury, or use of force
- The presence of a power imbalance between them which precludes consent by the weaker person

29.5 The criminal law is applicable in some of these situations - ([see Legislative Framework, Appendix 1](#)).

29.6 Where there are concerns about the mutuality of the relationship and/or consent of one of the individuals the same process of determining whether there is consent should be worked through.

29.7 Factors, which may indicate mutuality, are:

- Both parties seeking each other out
- Spending spare time together
- Sharing leisure activities
- Sharing resources equally
- Restricting activities with other potential partners

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APPENDIX 1

Legal Framework Applicable to Cases of Alleged/Suspected Abuse

1. Safeguarding the Welfare of Vulnerable People

1.1 People with a mental disorder – the Mental Health Act 1983

1.1.1 Current Situation

The Mental Health Act (1983) deals with the reception, care and treatment of mentally disordered patients, the management of their property and other related matters. There are four categories which come within the definition of "mental disorder". Three of the categories are "mental impairment", "severe mental impairment" and "psychopathic disorder". For any of these definitions to apply, the conditions must be associated with "abnormally aggressive or seriously irresponsible conduct" on the part of the persons concerned. The fourth category of "mental disorder" is mental illness.

In considering whether it is appropriate to use the Mental Health Act 1983 in situations of alleged abuse, regard should be taken of the mental health needs of the alleged perpetrator as well as the alleged victim, as sometimes abuse may be due to the mental disorder of the alleged perpetrator.

The most relevant parts of the Mental Health Act for the purpose of these guidelines are likely to be:

- Sections 2, 3 and 4 – deal with the compulsory admission to hospital, for assessment or treatment, of a person who is suffering from a mental disorder of a nature or degree which warrants detention in the interests of her/his health or safety or for the protection of others. Applications under these parts of the Act can be made either by the person's nearest relative or by an Approved Social Worker//Approved Mental Health Practitioner (ASW/AMHP), and supported by two doctors. A person suffering from a psychopathic disorder can only be detained for treatment if treatment is likely to alleviate or prevent a deterioration of their condition (known as the "treatability" test).
- Section 115 – under this section, an ASW/AMHP can enter and inspect any premises where a mentally disordered person is living if s/he has reasonable cause to believe that the patient is not under proper care. This Section does not give an ASW/AMHP power to enforce an entry, although a person refusing her/him entry may commit an offence under Section 129.
- Section 135 – under this section, an application can be made by an ASW/AMHP to a magistrate to enter premises with a police constable to remove a person believed to be suffering from a mental disorder to hospital or an alternative place of safety for up to 72 hours, where there is reasonable cause to suspect that the person believed to be suffering from a mental disorder has been ill-treated or neglected or kept otherwise than under proper control or is unable to care for her/himself and is living alone.
- Section 7 (Guardianship) - a person, aged 16 or over, may be received into

guardianship provided s/he suffers from a mental disorder of a nature or degree which warrants guardianship and guardianship is necessary for the welfare of the patient or the protection of others.

An application for guardianship is made to the Local Authority Social Services Department by an ASW/AMHP or the person's nearest relative and supported by two doctors.

Guardianship initially lasts for six months but may be renewed for a further six months and annually thereafter.

The guardian may be either the Social Services Department or a person who is acceptable to the Department. Once appointed, the guardian has the power to require the patient to live at a specified place, to attend at places and times specified for the purpose of medical treatment, occupation, education or training. They can require access to be given for example to doctors, or ASW/AMHPs, at any place where the person is living,

The Code of Practice of Mental Health Act (1983) sets out the purpose of guardianship as being to "enable patients to receive community care where it cannot be provided without the use of compulsory powers". It enables the establishment of an authoritative framework for working with a patient with the minimum of constraint to achieve as independent a life as possible within the community. Where it is used, it must be part of the patient's overall care and treatment plan. The code also outlines the essential components of effective guardianship.

- Section 117 – this sets out a duty owed to persons who have been compulsorily detained under the Act and have been discharged, for provision of aftercare services by the PCT or Health Authority and the local social services authority.

Other related legislation is:

- Mental Health (Patients in the Community) Act 1996
- Mental Health (After Care under Supervision) Regulations 1996. This Act provides a new framework for the supervision of patients aged 16 and over detained for treatment, under Section 117 of the Mental Health Act 1993.

- 1.1.2 Mental Health Act Code and 2007 Act amendments to the 1983 Mental Health Act
- The Mental Health Act 2007 amends the Mental Health Act 1983 and will take effect from the 3rd November 2008. The Mental Health Act 2007 does not abolish the Mental Health Act 1983; the old Act continues to exist but has key amendments brought in by the new Act. The new Code of Practice has been published on the Department of Health's website on <http://www.dh.gov.uk/publications>.
- There are 9 key changes to the amended Act and 5 guiding principles that guide practitioners in how to apply the Act and Code in individual situations. Please see the key changes listed below.

These are the main changes to the 1983 Act made by the 2007 Act, as stated by the Care Services Improvement Partnership on their website:-
(<http://www.mhact.csip.org.uk/news/latest-news/summary-of-the-amendments.html>):

- **“Definition of Mental Disorder:** it changes the way the 1983 Act defines mental disorder, so that a single definition applies throughout the Act, and abolishes references to categories of disorder. These amendments complement the changes to the criteria for detention.
- **Criteria for Detention:** it introduces a new “appropriate medical treatment” test which will apply to all the longer-term powers of detention. As a result, it will not be possible for patients to be compulsorily detained or their detention continued unless medical treatment which is appropriate to the patient’s mental disorder and all other circumstances of the case is available to that patient. At the same time, the so-called “treatability test” will be abolished.
- **Professional Roles:** it is broadening the group of practitioners who can take on the functions currently performed by the Approved Social Worker (ASW) and Responsible Medical Officer (RMO). The new role will be called an Approved Mental Health Practitioner (AMHP).
- **Nearest Relative (NR):** it gives to patients the right to make an application to displace their NR and enables County Courts to displace a NR where there are reasonable grounds for doing so. The provisions for determining the NR will be amended to include civil partners amongst the list of relatives.
- **Supervised Community Treatment (SCT):** it introduces SCT for patients following a period of detention in hospital. It is expected that this will allow a small number of patients with a mental disorder to live in the community whilst subject to certain conditions under the 1983 Act, to ensure they continue with the medical treatment that they need. Currently some patients leave hospital and do not continue with their treatment, their health deteriorates and they require detention again - the so-called “revolving door”.
- **Mental Health Review Tribunal (MHRT):** it introduces an order-making power to reduce the time before a case has to be referred to the MHRT by the hospital managers. It also introduces a single Tribunal for England, the one in Wales remaining in being.
- **Age Appropriate Services:** it requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs).
- **Advocacy:** it places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates.
- **Electro-convulsive Therapy:** it introduces new safeguards for patients.

The CSIP website also refers to a link to frequently asked questions about the changes. In addition to the changes listed, the 2007 Act makes changes to the Mental Capacity Act (MCA) providing for procedures to authorise the deprivation of liberty of a person resident in a hospital or care home who lacks capacity to consent. (See section 1.2 *Persons Who Lack Capacity*, below).

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1.2 People Who Lack Capacity - The Mental Capacity Act 2005

1.2.1 Introduction

The Mental Capacity Act 2005 (“MCA”) provides a statutory framework to protect people who lack capacity to make certain decisions. The MCA also works to protect carers and professionals when making decisions on behalf of persons who lack capacity. It makes it clear who can take decisions on behalf of a person who lacks capacity, in which

situations and how they should go about this. The Act starts from the fundamental point that a person has capacity and that all practical steps must be taken to help the person make a decision. The Act was fully implemented from October 2007 and must now be complied with.

1.2.2 Key principles

The key principles of the MCA are:

- **Presumption of capacity:** A person must be assumed to have capacity unless it is established that he or she lacks capacity.
- **Maximising decision-making capacity:** A person is not to be treated as unable to make a decision unless all practical steps have him/her to do so have been taken without success.
- **Unwise decisions:** A person is not to be treated as unable to make a decision because s/he makes an unwise decision.
- **Best Interests:** An act done, or a decision made, on behalf of a person who lacks capacity to decide for him/herself must be done or made in his/her best interests.
- **Least restrictive alternative:** When an act is done, or a decision made, on behalf of someone who lacks capacity to do so him/herself, regard must be had to what is the least restrictive of the person's rights and freedom of action.

1.2.3 When will a person lack capacity?

Capacity is decision specific. The MCA makes it clear that you cannot refer to someone as lacking capacity generally, but rather, you must look at whether a person lacks the capacity to make the specific decision in question.

A person is unable to make a decision for themselves if they:

1. have an impairment of, or disturbance in, the functioning of the mind or brain;
AND
2. are unable to make a decision for themselves.

Stage 1 of the test is known as a "diagnostic threshold". The Code of Practice for the MCA gives the following examples of where a person may have an impairment in or disturbance of the function of the mind or brain:

- Conditions associated with some forms of mental illness;
- Dementia
- Significant learning disabilities;
- Long-term effects of brain damage;
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness;
- Delirium;
- Symptoms related to head injury;
- Symptoms of alcohol or drug use.

Stage 2 of the test, is the inability to make the decision in question. The MCA provides that people are unable to make a decision for themselves if they cannot:

- Understand information about the decision to be made;
- Retain the information for long enough to use it to make the decision;
- Use or weigh the information as part of the decision making process; or
- Communicate their decision (this can include non-verbal forms of communication).

Some people will experience fluctuations in their capacity to make specific decisions. An assessment of a person's capacity to make a decision should be done when the decision is to be made and where at all possible, making a decision for a person who temporarily lacks capacity should be put off until capacity is regained.

1.2.4 Assessment of Capacity

Who makes an assessment of a person's capacity will depend on the decision to be made. For most day-to-day decisions, (for example, when to get up, what to eat), the carer most directly involved with the person's care at the time the decision has to be made should assess the person's capacity to make the decision. Where a legal transaction is involved, such as making a will or a Lasting Power of Attorney, the solicitor handling the transaction must decide whether the person has the required capacity, and may ask for the opinion of a doctor. Where consent to medical treatment or examination is required, the doctor proposing the treatment must decide whether the patient has the capacity to consent to or refuse treatment.

The more complicated or serious the decision is, the greater the degree of professional expertise required to assess whether a person has the capacity to make it. An assessment from a psychiatrist or other mental health professional will not always be needed to assess a person's capacity to make a specific decision. Where an expert's opinion is sought, it does not substitute for the decision of the person or agency required to make the decision ("the decision maker"); it is used to inform the decision maker only.

A formal expert's assessment of capacity must be obtained where:

- A person's capacity to sign a legal document could be challenged;
- Where it must be established that a person who is or is likely to be involved in litigation requires the assistance of the Official Solicitor or other litigation friend;
- Where the Court of Protection or other court is required to make a decision as to whether a person has or lacks capacity about a particular matter;
- Where there may be legal consequences of a finding of capacity.

A lack of capacity cannot be established merely by reference to a person's age, appearance, a condition they have, or an aspect of behaviour which might lead others to make unjustified assumptions about his capacity. This applies to people with a mental illness or disorder who are detained for treatment under section 3 of the Mental Health Act 1983; for example, it cannot be assumed that such persons lack capacity to make **all** decisions, including decisions regarding medical treatment outside of treatment given under s3 Mental Health Act 1983.

When assessing a person's capacity to make a specific decision, the following steps must be taken:

- All practicable steps to maximise a person's capacity including, for example, the use of simple language or visual aids in order to help the person understand the decision in question. The assessor must permit, encourage and improve the person's ability to participate;
- Consider whether the person can retain the information for long enough even if it is only a short period;
- Consider whether the person will regain capacity to decide at some point and if so, when that will be?
- Make sure the person has all the information or sufficient information in order to make the particular decision.

- Make sure that the information is explained or presented in a way that is easiest for the person to understand.
- Take into account whether there are particular times of the day when the person's understanding is better or locations where they feel more at ease. Consider postponing the decision to another occasion if that would be better.
- Consider whether the person can be helped or supported to make choices or express a view, by someone else, such as a relative or an independent advocate. If so, arrange for that to happen.
- Reach a decision based on the balance of probabilities; it is more likely than not that the person lacks capacity, but remembering that there is a presumption of capacity.

The graver the consequences of the decision the greater the level of competence is required to make the decision. A legal case, *RET, (an Adult) (Consent to Medical Treatment) [1993]* gives some background to this and if there is any doubt, contact should be made with legal services.

1.2.5 Best Interests checklist

Someone who makes a decision on behalf of a person who lacks capacity to make it themselves must only do so in the best interests of that person, and it must be the least restrictive of their basic freedoms. The decision maker must consider the following:

- Whether it is likely that the person will at some time have capacity for the decision in question and if so, when?
- So far as is reasonably practicable, encourage the person to participate as fully as possible in any decision.
- If the decision relates to life-sustaining treatment he must not be motivated by a desire to bring about death.
- Consider past and present wishes and feelings, any written statement made when he had capacity, the beliefs and values that would be likely to influence his decision if he had capacity, the other factors he would consider if he had capacity.
- He must consult anyone named by the person as someone to be so consulted.
- Anyone caring for the patient or interested in his welfare, any person appointed under a Lasting Power of Attorney.
- Any Deputy appointed by a Court.
- The views of an Independent Mental Capacity Advocate (IMCA), if one has been engaged

NOTE: No-one can consent on behalf of patient to sexual relations, marriage, divorce, adoption or to vote.

The Court of Protection now has jurisdiction to make declarations as to what is in the best interests of a person who lacks capacity. The MCA has also brought in:

- the ability for people to appoint others, under a Lasting Power of Attorney ("LPA"), to make welfare decisions for them when they lose capacity;
- the ability for the Court of Protection to appoint a Deputy who can make ongoing welfare decisions for a person.

Persons acting as a Deputy or a donee under a LPA must follow the principles of the MCA and act in the best interests of the person who lacks capacity.

Agencies must act in the best interests of persons who are unable to make decisions themselves. If there is a conflict between what an agency believes and what a person appointed under an LPA or a Deputy believes is in a person's best interests, the matter should be resolved by the Court of Protection. It may also be appropriate to refer the matter to the Court of Protection in other disputes about best interests of a person lacking capacity, between agencies and other persons, most often friends and relatives of the person lacking capacity.

The consequences of taking decisions for people who lack capacity under the MCA, with the reasonable belief that the decision taken is in the persons best interests, is that carers/professionals will be protected from liability.

1.2.6 Independent Mental Capacity Advocates

The MCA creates a role for special advocates, the Independent Mental Capacity Advocates (IMCAs). The role of an IMCA is to support and represent the person who lacks capacity.

An IMCA **must** be instructed where:

- A local authority proposes to provide a person who lacks capacity with residential accommodation (under s21 National Assistance Act 1948 or under s117 Mental Health Act 1983), or make a change to the person's residential accommodation, for longer than eight weeks and there is no person whom it would be appropriate person to consult with about the person's best interests;
- An NHS body proposes to provide a person who lacks capacity with accommodation (in a hospital for longer than 28 days, or in a care home for longer than eight weeks), or change the person's accommodation to another hospital or care home (for the same length of time as above) and there is no person whom it would be appropriate to consult;
- An NHS body proposes to provide serious medical treatment to a person who lacks capacity and there is no appropriate person to consult.

There is a power to instruct an IMCA where:

- A local authority or an NHS body are to conduct a care review and there is no person whom it would be appropriate to consult;
- **In adult protection cases (where adult protection procedures have been initiated), whether or not there are family, friends or others could be consulted.**

See sections 35-41 MCA, Code of Practice for the MCA and Mental Capacity Act 2005 (Independent Mental Capacity Advocate) (Expansion of Role) Regulations 2006.

1.2.7 Code of Practice

A Code of Practice has been produced by the Department of Health. Persons making best interests decisions for people who lack capacity must be aware of the Code and have regard to it when acting and making decisions. There are also guides for people who require assistance, informal carers and professionals which can be downloaded from: -

www.dca.gov.uk/legal-policy/mental-capacity/mca-guide-for-professionals.pdf

1.2.8 Deprivation of liberty

The MCA permits reasonable restraint of persons who lack capacity in certain circumstances as follows:

1. the person restraining reasonably believes it is necessary to prevent harm to the person lacking capacity; and
2. it is proportionate to the likelihood and the seriousness of the harm; and
3. if it does not constitute detention (which is a breach of a person's human rights under Article 5 of the European Convention on Human Rights).

So while reasonable restraint is permitted, detention of a person's liberty is not currently permitted. The issue of deprivation of a person's liberty, where they lack capacity to make decisions about their living and care arrangements, is a problem that was highlighted in the famous case of *HL v UK* (2005) EHR 32, also known as the *Bournewood* case. Sometimes where the decision made on behalf of a person lacking capacity is for them to remain in a care home or a hospital, it will cross into a deprivation

of liberty. In the Bournemouth case, the court said that the difference between *mere restriction* and *deprivation* of liberty is one of “degree and intensity”, not one of “nature and substance”. Factors which may relate to the degree and/or intensity of the placement include:

- a. the type of care involved;
- b. how long the situation lasts;
- c. the effects of the situation on the person;
- d. how the situation came about and how the care is implemented;
- e. whether the person is ‘free to leave’ at all.

There are times when the local authority, or other person/agency responsible for the person who lacks capacity’s care, will decide that it is in the person’s best interests to remain under certain care arrangements which amount to a deprivation of liberty. At the moment, only the Court of Protection can authorise such a deprivation of liberty in a person’s best interests. Before proceeding with an application to the Court of Protection, it is advisable to consider whether guardianship under the Mental Health Act 1983 is applicable for requiring a person to live at a certain place.

The Mental Health Act 2007 amends the MCA and creates a procedure to authorise deprivations of liberty in the best interests of a person who lacks capacity to make decisions about where they should live and their care or treatment. These are known as the ‘deprivation of liberty safeguards’ and came into effect on 1 April 2009. Under the procedure, where a hospital or care home identifies that a person is, or is at risk of, being deprived of their liberty, they must refer the matter to the ‘supervisory body’. Where the person is in a care home, the supervisory body will be the local authority. Where a person is a patient in hospital, the supervisory body will be the Primary Care Trust (PCT). Department of Health guidance states that, “The deprivation of liberty safeguards do not introduce a new system for determining whether a person who lacks capacity to decide the matter for themselves should receive care or treatment. Nor do they provide any new power to take and convey people to hospitals or care homes. They are solely about ensuring that there are appropriate safeguards in place when it is deemed that a person who lacks the capacity to decide the matter for themselves needs to receive care or treatment, in their best interests, in a hospital or care home, in circumstances that deprive them of their liberty”.

(see: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080718).

When a supervisory body receives a request for authorisation of deprivation of liberty they must obtain 6 assessments:

1. Age Assessment – the person in question is aged 18 or over
2. Mental Health Assessment – they are suffering from a mental disorder
3. Mental Capacity Assessment – they lack capacity to decide whether to be admitted to or remain in a hospital or care home
4. Eligibility Assessment - the person is eligible unless they are:
 - detained under the Mental Health Act 1983;
 - subject to a requirement under the Mental Health Act 1983 that conflicts with the authorisation sought e.g. a guardianship order requiring them to live somewhere else;
 - subject to powers of recall under the Mental Health Act 1983; or
 - unless the application is to enable mental health treatment in hospital and they object to being in hospital or to the treatment in question. In deciding whether a

person objects, their past and present behaviour, wishes, feelings, views, beliefs and values should be considered where relevant.

5. Best Interests Assessment – the proposed course of action would constitute a deprivation of liberty and it is:
 - in the best interests of the person to be subject to the authorisation; and
 - necessary in order to prevent harm to them; and
 - a proportionate response to the likelihood of suffering harm and the seriousness of that harm.
6. No Refusals Assessment – the authorisation sought does not conflict with a valid decision by a donee of a Lasting Power of Attorney or by a Deputy appointed for the person by the Court of Protection, and is not for the purpose of giving treatment that would conflict with a valid and applicable advance decision made by the person.

The department of health has published a Code of Practice for the deprivation of liberty safeguards, and has also published transitional arrangements for the implementation. Both can be found on the department of health's website: www.dh.gov.uk.

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1.3 Removal from Home of Certain Vulnerable Adults *Section 47 of the National Assistance Act 1948*

This Act allows the removal to suitable premises of persons in need of care and attention. Application must be made by the Local Authority to a Magistrates Court based on the certification to be provided for an application under Section 1 of the National Assistance (Amendment) Act 1951 is to be provided by a proper officer of the Local Authority or a District Community Physician and secondly, by a registered medical practitioner (usually the GP).

The grounds are that:

- The person is suffering from grave chronic disease *or*, being aged, infirm or physically incapacitated, is living in unsanitary conditions, and
- The person is unable to devote to her/himself and is not receiving from other persons proper care and attention, and
- The community physician certifies in writing that they are satisfied that her/his removal from home is necessary either in her/his own interests or for preventing injury to the health of, or serious nuisance to, other persons.

The Court may order that an officer of the Local Authority remove the person to a suitable hospital or other place. The Order lasts for an initial period of three months with the Court having power to extend it for further periods of up to three months.

The Local Authority must give seven days' notice to the person in respect of whom the application has been made, or to the person in charge of him before a Section 47 application can be considered by the Court.

In an emergency situation, where it is necessary to remove the person from her/his home without delay, it is possible to make an application without notice. This order lasts for three weeks. It must be based on certificates from the Consultant in Communicable Disease Control and another Doctor (usually the GP) including that it is in the interests of the person to be removed without delay.

In practice these powers are used rarely and should only be considered when all other alternatives have been exhausted.

Section 47 is inappropriate where:

- There is evidence of mental impairment which inhibits the person from making

valid judgements about her/his situation and this mental impairment is not secondary to acute physical illness;

- Public health hazards and unhygienic conditions can be dealt with under the public health acts;
- Additional community resources would alleviate the situation.

It should be noted that if a person is in need of medical treatment a doctor could arrange admission to hospital under the common law duty of care.

A decision to use Section 47 should only be made after a formal multi-agency meeting. The meeting must be convinced that removal from home would lead to a substantial improvement in the person's health.

Every effort should be made to ensure that the person subject to a Section 47 application has legal representation.

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1.4 Entering and Cleaning Homes *Public Health Act (1936)*

Local authorities have powers under public health legislation to enter and cleanse premises constituting a public health risk. A Magistrates' warrant is normally required, e.g. to inspect premises under Section 287 of the Public Health Act 1936. While these powers were not designed with the protection of vulnerable adults in mind, they can sometimes be helpful in conjunction with, or even instead of, the use of other statutory powers.

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1.5 The Family Law Act 1996

Under this Act the High Court, County Court or Magistrates Court may make Occupation Orders which may provide who shall occupy the home and the Court may direct another party to leave. Factors to be considered and the exact nature of the Order vary according to who is legally entitled to occupy the property and the relationship between the parties.

Non-Molestation Orders prohibit the respondent from the molesting of a person with whom he or she is associated.

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1.6 Provision of Services by the Local Authority

1.6.1 Residential Accommodation – Section 21 National Assistance Act (1948)

Local authorities are under a duty to provide residential accommodation for persons who, by reason of age, illness, disability or any other circumstances, are in need of care and attention which is not otherwise available to them.

1.6.2 Domiciliary and Day Care Services - Chronically sick and Disabled Persons Act 1970 S2(1), Health Services and Public Health Act 1968 S13(1.) Residential Homes Act 1989 S(8)

Including duties and powers to provide practical assistance in the home, provision of adaptations, holidays, meals on wheels, telephone installation or recreational facilities.

1.6.3 Disabled Persons (Services, Consultation, and Representation Act) 1986

As its title indicates, the act provides disabled people and their carers with a range of

rights covering services.

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1.7 Legislation for Carers

On occasions it may be that a vulnerable person may be at risk of harm from their family or informal carer, as a result of the stress caused through their caring role. Actions taken under the following legislation may be used in a protection plan to alleviate stress and reduce the risk, or a re-occurrence, of a vulnerable person suffering harm.

1.7.1 *The Carers (Recognition and Services) Act 1995*

This Act places a **duty** on local authorities to assess carers (who are not employed under a contract of employment or as volunteers for a voluntary organisation), upon the carer's request, who provide, or intend to provide, a substantial amount of care on a regular basis to:

- A person who is being assessed under Section 47 of the NHS and Community Care Act, 1990; or
- A disabled child who is being assessed under the Children Act 1989.

1.7.2 *The Carers and Disabled Children Act 2000*

This Act has extended local authorities responsibilities towards carers:

- Carers now have a right to an Assessment even in circumstances where **the cared for person has refused a Community Care Assessment;**
- Parent carers of disabled children have a right to their own assessment;
- Councils have the **power** to provide services directly to carers to support the carer in their caring role or to maintain their own health and well being;
- Councils have the **power** to make direct payments to carers to meet their own assessed needs. This includes 16 or 17 year old carers in certain circumstances;
- Councils have the **power** to make direct payments to parent carers to meet the assessed needs of the disabled child and the
- Councils have the **power** to make direct payments to 16 and 17 year old people with disabilities.

1.7.1 *The Carers (Equal Opportunities) Act 2004*

This Act states that:

- local authorities are given a **duty** to inform carers of their entitlement to an assessment under the 1995 Act, who must be informed about their right to a carer's assessment.
- carers assessment must consider the wishes of the carer in relation to leisure, education, training and desire to return to work;
- there should be co-operation between local authority and other public authorities, including housing, education, health, in the planning and provision of services to carers to support them in their caring role.

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1.8 Race and Sex Discrimination

1.8.1 *Race Relations Act 1976*

Where abuse or neglect appears to have its origins in racist behaviour (including some

discrimination on the grounds of religious beliefs in some circumstances), this Act may apply. The Act deals with unlawful discrimination on racial grounds in the fields of employment, provision of goods and services, education and exercise of functions by public bodies, and the ability to take legal action in cases of unlawful discrimination.

1.8.2 *Race Relations (Amendment) Act 2000*

This extends protection against racial discrimination and places a new, enforceable positive duty on public authorities. Local authorities must publish a race equality scheme.

1.8.3 *The Sex Discrimination Act 1975*

This Act renders discrimination on the grounds of marriage unlawful. The Act was amended by the Sex Discrimination Act 1986, removing certain restrictions applying to the working hours and other working conditions of women.

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1.9 Housing
The Housing Act 1985 Part 111 (Homelessness)

Section 66: Local authorities have a preventative duty to take reasonable steps to ensure that accommodation does not cease to become available for applicants threatened with homelessness.

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1.10 Duty of Care to Vulnerable Adults
X & Y v LB Hounslow (2008)

The case of X & Y v Hounslow is the first example of a local authority being held to have been negligent to a vulnerable adult.

The tort of negligence will only be made out if the authority owes a duty of care to a person(s), that it has breached that duty and that the breach of duty caused the claimant to suffer loss or damage.

In this case, X and Y had learning difficulties. They lived in a council flat on an estate with their children. Various departments of the defendant local authority (teams in the Housing and Social Services departments) received information that they were being exploited by youths on the estate, including that the youths were using the couple's flat to store allegedly stolen goods and were using it as a place to have sex. There were also threats of violence and actual violence against Y. They suffered a terrible ordeal of physical abuse by those youths one weekend, in which they had been imprisoned in their own home, and repeatedly assaulted and abused, often in the presence of their children.

X and Y brought proceedings against the local authority in negligence. They contended that the authority owed them a duty of care, specifically to move them into some sort of alternative accommodation at some stage before the relevant weekend, and that it could have done so under its emergency system for transferring tenants to temporary accommodation in extreme cases involving severe violence or harassment.

The authority replied that X and Y had no right of action in negligence because they were effectively challenging a failure to re-house them, which could only be challenged by way of judicial review.

An argument was made by the local authority that the acts/omissions by Social Services and Housing Departments should be considered separately. The main issue for the court was whether the authority was under a duty of care to the claimants and whether there had been a breach of any such duty such that the local authority were liable in negligence to X and Y.

The court held that:

- the authority should be considered as a single entity. Each of the sections and departments was under a duty to communicate with the others and amongst its own members of staff the information that it had received. The authority was, in law, a single entity, and was sued as such. Each relevant department and section knew that the others were involved with X and Y or their children, and they had communicated with each other from time to time. Also, moving the family from their flat might require input from both of the departments in question.
- A duty of care existed on the evidence, for the following reasons, applying the principles of negligence law:
 - it was *reasonably foreseeable* that either or both X and Y would suffer a serious physical attack from local youths in their flat;
 - the relationship between the authority and X and Y was of *sufficient proximity* (closeness) to give rise to a duty of care as the authority was their landlord and provided social services for them;
 - it was fair, just and reasonable to impose a narrow duty of care to move the claimants out of the flat in response to the particular, unusual, but highly dangerous, situation that had developed. The extension of a duty of care to the claimants would involve a small step in extending the law in which duties of care had been found to be owed by local authorities to children, rather than a giant leap, which the case law says should be avoided. X and Y functioned in many ways like children. Previous cases also demonstrated a greater willingness to find the existence of duties of care subsequent to the passing of the Human Rights Act 2003.
- The authority could have invoked its emergency system to move the claimants, it should have done so, and had it done so, alternative accommodation would have been found. This was a situation of severe violence and harassment, and therefore satisfied the authority's own test for the invocation of that system. The authority had a procedure that it could have used before the relevant weekend. The claim was not based on the action and inaction of both Housing and Social Services in response to information received by them about X and Y's situation and the danger posed to them. In all the circumstances, that breach of duty had *caused* the claimants' injury and loss.

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2. Safeguarding the Finance and Property of Vulnerable Adults

2.1 Local Authority duty to protect property

S48 National Assistance Act 1948

A local authority must take reasonable steps to prevent or mitigate the loss or damage to movable property of a person where the person:

1. Is admitted as a patient to a hospital
2. Is admitted to accommodation which is provided under Part 3 of the National Assistance Act 1948
3. Is removed to any place under an Order made under Subsection 3 of section 47 of this act. (Removal from home - see Legal Appendix)

And it appears that there is danger of loss or damage to any movable property, and no other suitable arrangements can be made.

The Local Authority has the power, in certain circumstances, to force entry to premises and to recover payment.

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2.2 Management of money and property

2.2.1 Third party mandate

A person can issue a mandate for someone to have access to their bank or building society account to collect money on their behalf. The presumption is that the person would have sufficient mental capacity to be able to do so.

2.2.2 Agency

A person in receipt of social security benefits can appoint an agent to collect their pension or other state benefits from the Post Office. On a temporary basis this can be done by completing the back of the pension book with the name of the person appointed as agent. A permanent arrangement needs to be made through the local benefits office. The authorisation is to collect money only and the agent has no power to spend the money without specific further authorisation.

2.2.3 Ordinary Power of Attorney

This is a deed (a particular form of legal document) whereby donors can appoint attorney(s), either on a temporary or a longer term basis, to act on their behalf in financial matters, while they are still capable of acting for themselves. The process for doing this was established under the Powers of Attorney Act 1971.

The power of attorney can be limited to a specific transaction or granted as a general power. It is only valid in law whilst the person giving his/her authority is fully mentally capable to make decisions about their property and affairs. If there is any doubt about the capability of a person to sign, it is recommended that the signature be witnessed by an independent person (e.g. doctor).

A power of attorney must be made on the prescribed legal forms. It will become invalid if the donor becomes mentally incapable due to mental disorder.

2.2.4 Enduring or Lasting Power of Attorney

If an individual becomes mentally incapacitated an ordinary power of attorney becomes invalid. The Enduring Power of Attorney Act 1985 enables a person to appoint an attorney to continue to manage their property and affairs when they become mentally incapable. These are Enduring Powers of Attorney (EPAs). Once the attorney is aware that the individual is becoming incapacitated they have a duty to register her/his enduring power of attorney with the Court of Protection. EPAs were replaced by Lasting Powers of Attorney (LPA) from the 1 October 2007, under the Mental Capacity Act 2005. Existing EPAs before that date are still valid, but any new appointment is a LPA.

Like the EPA a LPA has to be made when the person has capacity but takes effect by registration with the Court of Protection after the person has lost capacity. The main difference between and EPA and a LPA is that under the new provisions the person can

appoint an individual to decide on matters of welfare, not just property and finance.

2.2.5 Appointeeship

The Secretary of State is empowered to appoint someone (“the appointee”) to exercise on behalf of a social security claimant (“the claimant”) when the claimant is incapable of acting. The appointee is able to receive and deal with any social security benefits payable. An appointee can collect, deal with and spend the benefit to pay expenses, for example, food, bills, personal care. An appointee does not have the authority to deal with capital or other income belonging to the incapacitated person. The claimant of benefits must be unable to act for her/himself.

The appointee must complete a form BF56 and apply, in writing, to receive the money due to the claimant. The Benefits Agency must satisfy themselves as to the claimant’s ineligibility to manage her/his affairs and as to the suitability of the proposed appointee.

The appointee can be anyone who knows the claimant well, usually a partner or close adult relative. However, if no suitable person is available, Islington Social Services Department can take responsibility as the Corporate Appointee for appointeeship. (Social Services staff should consult the Community Care Division.)

Where appointeeships are held by residential and nursing home managers, this should be carefully monitored by the placing Authority.

If doubts arise regarding the conduct of an appointee, the matters should be referred to the Benefits Agency who have the power to and will take away the rights of an appointee who is not acting properly or in the best interests of the claimant.

It should be noted that while a power of attorney, enduring power of attorney and appointeeship can be used to protect vulnerable adults, these powers can also be used to take advantage of them.

The powers invested in an appointeeship are overridden when a Deputy is appointed or if the service user has made an EPA or a LPA while mentally capable.

Where a mentally incapacitated person has assets, which are substantially over the level of state benefits, an Appointee must instigate an application to the Court of Protection for the appointment of a Deputy.

The Secretary of State can revoke an appointeeship at any time. An Appointee may resign his/her appointeeship by giving one month's notice. An appointeeship ceases automatically as soon as:

- the claimant is able to act for themselves
- a Deputy, other than the Appointee, has been appointed
- the claimant or the Appointee dies
- the appointeeship is transferred to another person

If the Appointee does not comply with the conditions on which it was granted, the appointeeship can be withdrawn.

The Appointee should notify the Benefits Agency of the death of the claimant at the earliest opportunity, and send an original copy of the white death certificate issued by

the Registrar for this purpose if possible.

2.2.6 Court Appointed Deputies

If there is no EPA or LPA, the Court of Protection can appoint a Deputy to act. The Court of Protection deals with the management of the property and affairs of some mentally disordered people. From April 2007, a new Court of Protection was established under the Mental Capacity Act 2005. It exists to safeguard the interests of anyone who, by reason of mental disorder, is incapable of:

- managing and administering their property and affairs and;
- making decisions about their welfare.

The Court of Protection Rules 2007 define the role of the Court and the Public Guardian. The Office of the Guardian (OPG), previously the Public Guardianship Office, is responsible for administering the court's decisions. The OPG registers LPA's and works together with other agencies such as the police and social services, to respond to any concerns raised about a donee under an LPA.

A medical assessment is required for an application for the appointment of a Deputy. The court will only accept jurisdiction if it is satisfied that the person lacks capacity to make certain decisions.

See section 1.2 *People Who Lack Capacity*, above, for definitions of mental incapacity. An application must be made to the Court of Protection for the appointment of a Deputy when:

- The person without capacity has assets in excess of £5,000 and other means such as EPA or LPA are not possible either because one is not in existence or it was granted for limited application only.
- The balance in miscellaneous savings/ residents savings accounts is less than £5,000 but there are funds lodged elsewhere for example in banks, building societies, over which an Appointee has no control, which need to be used on the client's behalf.

A Deputy is a person appointed by the Court to deal with the day to day management of the patient's financial affairs, similar to the old system of 'receivers' under the Mental Health Act 1983. He or she can be a relative, friend, professional adviser such as a solicitor, or an official of the local authority. If there is no one else suitable or willing to act, the Public Guardian can appoint a "Panel Deputy" who would normally be a solicitor with specific knowledge or experience, and who gets paid to act from the person's assets.

A Deputy has power to do all things in relation to the property and financial affairs of the person that the Court of Protection orders or authorises.

Generally, the Deputy is responsible for receiving the person's income and ensuring that it is collected from all sources and using it to pay the person's living costs and to settle any debts. Any surplus must be used for that person's benefit, which would also include prudent reinvestment of income for their short and long-term requirements.

The Deputy's powers are listed in the Court Order appointing the Deputy and they may be either general or of a specific nature. It is usually necessary to obtain further specific authority from the Court where matters of a non-routine nature need to be dealt with. Examples of this are:

- Buying and selling property

- Incurring overdrafts
- Taking and defending legal proceedings
- Making or changing a will

The Deputy has a duty to account to the Court annually or as and when required by the Court, for the handling of the person's financial affairs. As with Appointeeships and Powers of Attorney, the Deputy appointed to manage finance and affairs does not have any power to make decisions about the person's welfare (for example, where the person should live).

However, the Court can now make specific decisions relating to welfare matters and can also appoint a Deputy for Personal Welfare if there are ongoing decisions on welfare matters. This can be someone other than the Deputy for Property and Financial Affairs. In practice, it is unlikely that welfare Deputies will be appointed very often as there is a preference for specific and 'one-off' best interests decisions about a person's welfare.

Should the person regain the capacity to manage and deal with their finance and property, the person may at any time apply for an order to bring the proceedings in the Court (for example, the Deputyship Order) to an end. They, or the Deputy, must produce medical evidence of their recovery to the Court.

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3. Criminal Law - Violence and Criminal Offences Against Vulnerable Adults

A wide range of different types of adult abuse may be dealt with under criminal law: assault, sexual assault, actual and grievous bodily harm, fraud or theft. The role of the police is to investigate the crime and to forward papers on to the Crown Prosecution Service who then decide whether to prosecute.

There are two stages in the decision to prosecute. First there is the evidential test; this is that the Crown Prosecutor must be satisfied that there is enough evidence to provide a "realistic prospect of conviction". Secondly, if the case passes the evidential test, the Crown Prosecutor must decide if a prosecution is needed in the public interest. Public interest factors that affect the decision to prosecute usually depend on the seriousness of the alleged offence or the circumstances of the defendant.

Some common public interest factors in favour of prosecution relevant to these guidelines are:

- The defendant being in a position of authority or trust
- The victim of the alleged offence being vulnerable
- A marked difference between the actual or mental ages of the defendant and the victim, or if there is any element of corruption
- There are grounds for believing that the alleged offence is likely to be continued or repeated.

Some public interest factors against prosecution include the following:

- A prosecution is likely to have a very harmful effect on the victim's physical or mental health, always bearing in mind the seriousness of the offence
- The defendant is elderly or is, or was, at the time of the offence suffering from significant mental or physical ill-health, unless the alleged offence is serious or there is a real possibility that it may be repeated.

If the defendant admits the offence, cautioning is the most common alternative to a court appearance. (*Appendix 3 has some guidance on charging standards in cases of assault. See also Section 16 of the Mental Capacity Act 05 – the five key principles need to be borne in mind when working with people who may lack capacity to make their own decisions.*)

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3.1 Sexual Offences Against People with a Mental Disorder - Sexual Offences Act 2003

Sections 30-44 in the Sexual Offences Act 2003 relate to people with a mental disorder in England and Wales.

Mental disorder is defined as in the Mental Health Act 1983: "mental illness, arrested or incomplete development of the mind, psychopathic disorder and any other disorder or disability of the mind". The categories of mental disorder under the Mental Health Act 1983 are referred to in paragraph 1.1.1 above. This definition includes a person with a learning disability. Please note that the Mental Health Act 2007 will amend the definition of "mental disorder" in the Mental Health Act 1983 to any disorder or disability of the mind, and will abolish the categories of mental disorder.

The offences are grouped under three categories, which will be outlined further below:

- Victim unable to agree to sexual activity because of a mental disorder which impedes choice (Sections 30-33).
- Victim may have agreed to sexual activity through vulnerability from inducement, threat or deception (Sections 34-37).
- Victim in a relationship of care with perpetrator of offence (Sections 38-41).

It is important to state that where a person with a learning disability has the capacity to consent to sexual activity then they have the same right as anyone else to do so.

Where a non-consensual offence is committed against a person with a learning disability, for example, rape or sexual assault, the defendant will be charged with the same offences as anyone else. The following specific categories of offence relate to different situations where a mentally disordered person lacks capacity, or the sexual activity is with a care worker.

3.1.1 Sexual offences against persons with a mental disorder impeding choice (incapable of refusing)

Section 30: Sexual activity with a person with a mental disorder impeding choice.

Section 31: Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity.

Section 32: Engaging in sexual activity in the presence of a person with a mental disorder impeding choice.

Section 33: Causing a person, with a mental disorder impeding choice, to watch a sexual act.

This makes it an offence if a person is unable to refuse involvement in a sexual activity because of a mental disorder or for reasons related to it.

The person is deemed to be unable to refuse if they lack the capacity to refuse or communicate refusal. This can include, for example lack of capacity to:

- Understand the nature or consequences of the activity
- Realise that sexual activity is different to personal care
- Realise s/he has a choice
- Communicate their decision.

For these offences to be made out the defendant must know, or reasonably be expected to know that the victim has a mental disorder and because of that disorder is likely to be unable to refuse sexual activity.

3.1.2 Inducements to people with a mental disorder

Section 34: Inducement, threat or deception to procure sexual activity with a person with a mental disorder.

Section 35: Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception.

Section 36: Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder.

Section 37: Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception.

It is recognised that some people with a learning disability can, and do, have the capacity to consent to sexual activity but that they may be more susceptible to bribes or threats than others.

These offences address situations where inducements, threats or deceptions are used by the defendant to obtain agreement to sexual activity by someone with a mental disorder.

Inducements could be things such as promises of holidays, marriage or favours. Threats could include the perpetrator saying they would harm the victim, or their family or friends.

Deceptions could be perpetrators saying that this is something that all friends do. For these offences to be made out, it is also required that the defendant knew, or could reasonably be expected to know that the person had a mental disorder.

3.1.3 Care workers for people with a mental disorder

Section 38: Care workers: sexual activity with a person with a mental disorder.

Section 39: Care workers: causing or inciting sexual activity.

Section 40: Care workers: sexual activity in the presence of a person with a mental disorder.

Section 41: Care workers: causing a person with a mental disorder to watch a sexual act.

This third category of offences is to protect a person with a mental disorder from any sexual activity with someone responsible for their care. This would be an offence, whether or not the person with the mental disorder consented. It is anticipated that many victims in this situation may consent to their carer.

It is to be taken with this category of offences that the defendant knew that the person had a mental disorder because of their relationship, unless sufficient evidence is produced to the contrary.

It is important to point out that the last two offences in this section are not intended to stop workers carrying out sex education with the people they work with. It needs to be proved that the activities are carried out for the sexual gratification of the offender, therefore sex education as part of an agreed care plan for an individual would not be included within this.

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Definitions

Care worker [Section 42]

- Workers from care/community/voluntary/children's homes.
- Workers from NHS Services or independent medical agencies.
- People in regular face-to-face contact with a client, regardless of whether they provide
- Physical or mental care.
- Paid or unpaid, full- or part-time.

Consent [Section 74]

If a person agrees by choice and has the freedom and capacity to make that choice.

Sexual [Section 78]

An activity is sexual if a reasonable person would either always consider it to be sexual because of its nature, e.g. oral sex, or that it may be deemed to be sexual depending on the circumstances and intention. For example, a medical examination in a doctor's surgery, where the purpose is not sexual, would not be considered an assault.

Touching [Section 79(8)]

This covers a wide range of behaviour involving touching any part of the body with anything else and through anything such as clothing.

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3.2 Mistreatment or Wilful Neglect of Person with Mental Disorder

Under section 127 of the Mental Health Act 1983, it is a criminal offence for a person who is a staff member or is one of the managers of a hospital or a care home to ill treat or wilfully neglect a patient who:

- Is receiving treatment for a mental disorder as an in-patient in the hospital or home; or
- Is receiving treatment as an out-patient on premises of which count as part of the hospital or care home; or
- Is subject to guardianship or is otherwise in a person's custody or care (whether by legal or moral obligation or otherwise).

A person who is guilty of this offence may be liable to a term of up to 2 years imprisonment and/or a fine

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3.3 Mistreatment or Wilful Neglect of a Person lacking Capacity

Under s44 of the Mental Capacity Act 2005, it is a criminal offence for a person ("D") to wilfully neglect or ill treat another person ("P") where D:

- has the care of a person who lacks capacity, or whom D reasonably believes to lack capacity;
- is the donee of a power under a Lasting Power of Attorney or Enduring Power of Attorney, created by P when they had capacity;
- is a Deputy appointed by the Court of Protection for P.

A person found guilty of such an offence may be liable to a term of up to 5 year's imprisonment and/or a fine.

3.4 Police and Criminal Evidence Act 1984

Where the police are taking action against an alleged perpetrator who themselves are vulnerable, i.e. they are under 17, or have a mental disorder or learning disability they will be required to appoint an appropriate adult. (Refer to guidelines held in Community

Care Division.)

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3.5 Physical Abuse

3.5.1 Criminal Justice Act 1988 Section 39

What is known in law as “common” assault may leave no physical evidence. It can cover a wide range of language and conduct. Any act or words, involving a use or a threat of violence towards someone will constitute an assault. If no-one has witnessed the assault, prosecution is unlikely, as it is the perpetrator’s word against the victim’s.

Serious offences where the assault results in injury:

- **Assault occasioning Actual Bodily Harm** (‘ABH’ - Section 47, Offences against the Person Act 1861).
- **Assault occasioning Grievous Bodily Harm** (‘GBH’ – Sections 18 and 20, Offences against the Person Act 1861).

3.5.2 Domestic Violence, Crime and Victims Act 2004

This Act is the biggest overhaul of domestic violence legislation for thirty years and heralds tough new powers for the police and the courts to tackle offenders, while ensuring victims get the support and protection they need. For the first time, a statutory code of practice provides a range of rights to victims together with the establishment of an independent Commissioner. The Act will ensure more offenders pay towards supporting victims. The Criminal Injuries Compensation Authority will be able to recover money from offenders and a surcharge will be placed on criminal convictions and fixed penalty notices, which will contribute to the Victims Fund. For motoring offenders the surcharge will only apply to the most serious and persistent offenders. The Act also creates a new offence of causing or allowing the death of a child or vulnerable adult. This will help to ensure that offenders who remain silent or blame each other do not escape justice.

Key provisions in the Act include:

- Making common assault an arrestable offence which means that the police can arrest without a warrant.
- Significant new police powers to deal with domestic violence including making it an arrestable, criminal offence to breach a non-molestation order, punishable by up to five years in prison.
- Strengthening the civil law on domestic violence to ensure cohabiting same-sex couples have the same access to non-molestation and occupation orders as opposite sex couples, and extending the availability of these orders to couples who have never lived together or been married.
- Stronger legal protection for victims of domestic violence by enabling courts to impose restraining orders when sentencing for any offence. Until now, such orders could only be imposed on offenders convicted of harassment or causing fear of violence.
- Enabling courts to impose restraining orders on acquittal for any offence (or if a conviction has been overturned on appeal) if they consider it necessary to protect the victim from harassment. This will deal with cases where the conviction has failed but it is still clear from the evidence that the victims need protecting.
- Putting in place a system to review domestic violence homicide incidents, drawing

in the key agencies, to find out what can be done to put the system right and prevent future deaths.

- Providing a code of practice, binding on all criminal justice agencies, so that all victims receive the support, protection, information and advice they need.
- Allowing victims to take their case to the Parliamentary Ombudsman if they feel the code has not been adhered to by the criminal justice agencies.
- Setting up an independent Commissioner for Victims to give victims a powerful voice at the heart of government and to safeguard and promote the interests of victims and witnesses, encouraging the spread of good practice and reviewing the statutory code.
- Giving victims of mentally disordered offenders the same rights to information as other victims of serious violent and sexual offences.
- Giving the Criminal Injuries Compensation Authority the right to recover from offenders the money it has paid to their victims in compensation.
- A surcharge to be payable on criminal convictions and fixed penalty notices, which will contribute to the Victims Fund. For motoring offenders the surcharge will only apply to serious and persistent offenders.
- Creating a new criminal offence of unlawfully causing or allowing the death of a child or vulnerable adult. The offence establishes a new criminal responsibility for members of a household where they know that a child or vulnerable adult is at significant risk of serious harm.
- Bringing in the Law Commission recommendation for a two-stage court trial to ensure that high volume crimes like fraud and Internet child pornography can be punished in full.

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3.6 Protection from Harassment Act 1997 (Section 2)

A person can be prosecuted under this Act if their conduct causes another to fear, on at least two occasions, that violence will be used against him/her. Such conduct includes verbal abuse.

Although court proceedings can only be considered after the second offence, the first incident should be reported to the police.

To provide protection from further violent conduct, a court can issue a restraining order or injunction, and/or impose a fine or imprisonment.

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3.7 Corporate Manslaughter and Corporate Homicide Act 2007

This Act came into force on 6 April 2008 and created a new criminal offence. Certain organisations, including incorporated companies and public bodies such as the NHS and local authorities, will be guilty of an offence if the way in which their activities are managed or organised:

- causes a person's death, and
- amounts to a gross breach of a relevant duty owed by the organisation to the deceased.

The organisation will be guilty if (and only if) the way in which its activities are managed or organised by senior management is a substantial element in the breach, i.e. a

substantial part of the failing must have occurred at a senior management level. The prosecution is not obliged to prove specific failings by individual managers but can aggregate management failings generally.

- a death has been caused as a result of the way in which the senior management of that organisation has arranged or managed the organisation's activities; and
- that the shortcomings in the organisations and management amount to a gross breach of a 'relevant duty of care' owed to the deceased.

A 'relevant duty of care' is defined within the Act. Where an organisation is convicted, it can be punished with an unlimited fine.

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3.8 Financial abuse

3.8.1 Theft Act 1968

Section 1 sets out the definition of theft; Theft is the dishonest appropriation of property belonging to another, intending to permanently deprive the owner of it.

Theft does not necessarily involve physically moving something. Any form of taking over of the rights of the owner is enough. Dishonesty has to be proved, and it is a defence to show a reasonable belief that the owner would have consented had she or he known.

Adults who are dependent on others may be reluctant to make a complaint that will enable the police to act. Also, the informality of care arrangements can make a prosecution for misuse of funds difficult.

3.8.2 Fraud Act 2006

Section 4 concerns fraud by abuse of position. It is an offence for a person who occupies a position where he/she is required to safeguard (or not act against) the financial interests of another person, to dishonestly abuse that position, with the intent of self benefit or to benefit others.

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4. Safeguarding People Receiving Care: People in Care Homes or Receiving Domiciliary Care - Care Standards Act 2000

4.1 National Minimum Standards for Care Homes - Older People and Adults 18-65

The National Minimum Standards for Care Homes for Older People and the National Minimum Standards for Care Homes for Adults, form the basis on which the Care Quality Commission (CQC) will determine whether such care homes comply with the Regulations supporting the Care Standards Act 2000, for example to meet the needs, and secure the welfare and social inclusion, of the people who live there.

The national minimum standards are core standards, which apply to all care homes providing accommodation and nursing or personal care for older people. The standards apply to homes for which registration as care homes is required.

While broad in scope, these standards acknowledge the unique and complex needs of individuals, and the additional specific knowledge, skills and facilities needed in order for a care home to deliver an individually tailored and comprehensive service.

Certain of the standards do not apply to pre-existing homes including local authority homes, "Royal Charter" homes and other homes not previously required to register. The standards do not apply to independent hospitals, hospices, clinics or establishments registered to take patients detained under the Mental Health Act 1983.

The National Minimum Standards for Care Homes for Older People and Adults focus on achievable outcomes for service users – that is, the impact on the individual of the facilities and services of the home. The standards are grouped under the following key topics, which highlight aspects of individuals' lives identified during the stakeholder consultation as most important to service users:

- Choice of home
- Health and personal care
- Daily life and social activities

- Complaints and protection
- Environment
- Staffing
- Management and administration

Both the National Minimum Standards for Care Homes for Older People and the National Minimum Standards for Care Homes for Adults contain requirements to ensure that the Service users are protected from abuse.

These requirements are that:

- The registered person (that is, the registered care home) ensures that service users are safeguarded from physical, financial or material, psychological or sexual abuse, neglect, discriminatory abuse or self-harm, inhuman or degrading treatment, through deliberate intent, negligence or ignorance, in accordance with written policies.
- Robust procedures for responding to suspicion or evidence of abuse or neglect (including whistle blowing) ensure the safety and protection of service users, including passing on concerns to the CQC in accordance with the Public Interest Disclosure Act 1998 and Department of Health (DH) guidance *No Secrets*.
- All allegations and incidents of abuse are followed up promptly and action taken is recorded.
- Staff who may be unsuitable to work with vulnerable adults are referred, in accordance with the Care Standards Act 2000, for consideration for inclusion on the ISA list.
- The policies and practices of the home ensure that physical and/or verbal aggression by service users is understood and dealt with appropriately, and that physical intervention is used only as a last resort and in accordance with DH guidance.
- The home's policies and practices regarding service users' money and financial affairs ensure service users' access to their personal financial records, safe storage of money and valuables, consultation on finances in private, and advice on personal insurance; and preclude staff involvement in assisting in the making of or benefiting from service users' wills.

4.2 National Minimum Standards for Domiciliary Care

The Care Standards Act 2000 brought domiciliary care agencies into the regulatory framework of CSCI. The National Minimum Standards for domiciliary care agencies including local authorities and NHS Trusts form the criteria by which CSCI will determine whether the agency provides personal care to the required standard. The purpose of these minimum standards is to ensure the quality of personal care and support which people receive whilst living in their own home in the community.

These standards establish the minimum required; i.e. they identify a standard of service provision which an agency providing personal care for people living in their own home must not fall below. The following Protection Standards are a requirement for the provision of care at home:

- Safe working practices
- Risk Assessments
- Financial protection
- Protection of the person

- Security of the home
- Records kept in the home

The general public is aware of the effects of child abuse; far less publicity is given to adult and elder abuse and many people, even those employed in providing care to adults, are still relatively unaware of the existence of abuse and its effects. Home care and support workers need to be aware that abuse does not have to be extreme or obvious. It can be unintentional, insidious and the cumulative result of ongoing bad practice. No organisation that is concerned with maintaining standards in the provision of professional care services can afford to ignore any form of abuse which affects the well being of the people for whom they are responsible.

The role that home care and support workers play in the lives of people, for whom they care, is extremely important. It is the home care workers and support workers who have a key role in recognising and protecting people from abuse. They have a responsibility to the people for whom they provide the care service, to minimise both the likelihood of abusive situations occurring and the effects that it can have and to contribute to monitoring anyone who may be considered to be 'at risk.'

It is essential that care is taken in all financial transactions undertaken on behalf of the service user and a full written record kept to safeguard both the service user and the home care or support worker and to ensure no misunderstandings occur. For similar reasons home care or support workers must never seek to profit from the care they provide to service users by the acceptance of significant gifts or bequests.

The safety of service users is very important and for this reason care must be taken when entering or leaving the premises of people receiving care. This includes the need to carry and show proper identification at all times.

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APPENDIX 2

CRIMINAL CHARGING STANDARDS IN CASES OF ASSAULT This table is intended to act as an aid to those dealing with assault cases. It should not be seen as exhaustive but as a guide only.	Common Assault	ABH S47 OAP	GH S20 OAP	Wounding S18 OAP
Graze	✓			
Scratch	✓			
Abrasion	✓			
Minor bruise	✓			
Swelling	✓			
Reddening to skin	✓			
Superficial cuts	✓			
Black eye	✓			
Loss/broken tooth		✓		
Temporary loss sensory function (including consciousness)		✓		
Extensive/multiple bruising		✓		
Displaced/broken nose		✓		
Minor fracture		✓		
Minor (not superficial) cuts		✓		
Permanent disability			✓	✓ +
Permanent loss of sensory function			✓	✓ +
Visible disfigurement (not minor)			✓	✓ +
Broken, displaced limbs or bones			✓	✓ +
Injury causing substantial blood loss			✓	✓ +
Injury resulting in lengthy treatment/incapacity			✓	✓ +
<p>+ requires an intent to wound or cause grievous bodily harm and infliction of harm. Evidence might include a repeated or planned attack, deliberate selection of weapon, adaptation of article to cause injury, prior threats, use of offensive weapon against or kicking victim's head</p>				
<p>Assault on a constable in execution of their duty. S5(1) Police Act 1964. If evidence of 'execution of their duty' is not available, consider Criminal Justice Act 1988 or S47 Offences Against the Person Act 1861.</p>		<p>Assault with intent to resist arrest. S38 Offences Against the Person Act 1861. Can be used for assaults on members of the public, e.g. store detectives. Unlike S5(1) Police Act this offence is indictable and can therefore be coupled with other indictable offences.</p>		

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APPENDIX 3

ADASS PROTOCOL FOR INTER- AUTHORITY INVESTIGATION OF VULNERABLE ADULT ABUSE

This agreement was ratified by the ADASS on 20th February, 2004 and is intended for adoption by all Local Authorities and Adult Protection Committees

1. Introduction

These arrangements recognise the increased risk to vulnerable adults whose care arrangements are complicated by cross boundary considerations. These may arise, for instance, where funding/ commissioning responsibility lies with one authority and where concerns about potential abuse and/ or exploitation subsequently arise in another. This would apply where the individual lives or otherwise receives services in another local authority area

2. Aims

This protocol aims to clarify the responsibilities and actions to be taken by local authorities with respect to people who live in one area, but for whom some responsibility remains with the area from which they originated.

This protocol should be read in conjunction with Section 3.8 of 'No Secrets' (DoH 2000) and LAC (93) 7 *Ordinary Residence*- Which identifies these responsibilities in terms of:

- 2.1 The authority where the abuse occurred in respect of the monitoring and review of services and overall responsibility for adult protection;
- 2.2 The registering body in fulfilling its regulatory function with regard to regulated establishments; and
- 2.3 The placing authority's continuing duty of care to the abused person.

3. Principles

- 3.1 The authority where the abuse occurs will have overall responsibility for co-ordinating the adult protection arrangements (and, for the purposes of this protocol, be referred to as the host authority)
- 3.2 The placing authority (i.e. the authority with funding/ commissioning responsibility) will have a continuing duty of care to the vulnerable adult.
- 3.3 The placing authority should ensure that the provider, in service specifications, has arrangements in place for protecting vulnerable adults and for managing concerns, which in turn link with local policy and procedures set out by the host authority.
- 3.4 The placing authority will provide any necessary support and information to the host authority in order for a prompt and thorough investigation to take place.
- 3.5 The host authority will make provision in service contracts, which refer to this protocol, outlining the responsibilities of the provider to notify the host authority of any adult protection concern.

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4. Responsibilities of Host Authorities

- 4.1 The authority where the abuse occurred should always take the initial lead on referral. This may include taking immediate action to protect the adult, if appropriate, and arranging an early discussion with the police if a criminal offence may have been committed.
- 4.2 The host authority will also co-ordinate initial information gathering, background checks and ensure a prompt notification to the placing authority and other relevant agencies.
- 4.3 It is the responsibility of the host authority to co-ordinate any investigation of institutional abuse. If the alleged abuse took place in a residential or nursing home, other people could potentially be at risk and enquiries should be carried out with this in mind.
- 4.4 The Care Quality Commission should always be included in investigations involving regulated care providers and enquiries should make reference to national guidance regarding arrangements for the protection of vulnerable adults.
- 4.5 There will be instances where allegations relate to one individual only and in these cases it may be appropriate to negotiate with the placing authority their undertaking certain aspects of the investigation. However, the host authority should retain the overall co-ordinating role throughout the investigation.

5. Responsibilities of Placing Authorities

- 5.1 The placing authority will be responsible for providing support to the vulnerable adult and planning their future care needs.
- 5.2 The placing authority should nominate a link person for liaison purposes during the investigation. They will be invited to attend any safeguarding adults strategy meeting and/ or may be required to submit a written report.

6. Responsibilities of Provider Agencies

- 6.1 Provider agencies should have in place suitable adult protection procedures to prevent and respond to abuse which link with the local inter-agency policy and procedures set out by the host authority.
- 6.2 Providers should ensure that any allegation or complaint about abuse is brought promptly to the attention of Social Services, the Police, and/ or the Care Quality Commission in accordance with local inter-agency policy and procedures
- 6.3 Provider agencies will have responsibilities under the Care Standards Act 2000 to notify their local CQC area office of any allegations of abuse or any other significant incidents.
- 6.4 Provider agencies who have services registered in more than one local authority area will defer to the CQC area office relevant to the area in which the abuse took place.

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APPENDIX 4

Safeguarding Adults in Islington Strategy Meeting Template

1. Client's initials: Date of Birth:
2. Details of significant others in client's life:
3. Date/Time:
4. Venue:
5. Chair of meeting:
6. Attendance sheet and statement of confidentiality completed and signed (see attached):
7. Introductions :
8. Purpose of meeting:
9. Chronology of details. This should include details of: <ul style="list-style-type: none"> • The incident/allegation/concern. • An outline of the alert, what happened/is alleged to have happened and when. • Details of any witnesses, who reported and when. • What is known about the alleged perpetrator. • Any relevant factors in relation to culture, religious background, health, disability, language, capacity, sexuality. • Brief social history/physical description of the client.
10. Actions already taken:
11. Does the client have the capacity to make decisions regarding this safeguarding alert? Yes/No . If No, has a family member, representative or advocate been consulted? If Yes, what are the views and wishes of the client regarding the alleged incident and possible investigation?
12. Contributions of other representatives/agencies present at this meeting:



13. Are there any other people vulnerable to abuse in relation to this case? Is the perpetrator a vulnerable adult?
14. Analysis of risks to the client and/or other people based on what is known now:
15. Decision to conduct investigation. Yes/No. If no, record reason for decision. If yes, does the client consent to a safeguarding investigation, if they have the capacity to do so (see 11 above). If No, record reason for proceeding.
16. Detail actions: who will do, and set timescales. Record name of Safeguarding Investigator and Safeguarding Manager:
17. Is a Protection Plan meeting needed? Yes/No. If no, why? If yes, who will convene? Is there a need for protection plans for other vulnerable adults?
18. Communication. Agree who should be advised of the outcome of this meeting. Agree who will communicate with whom. Remember to keep the client/their representatives informed appropriately.
19. Review of strategy. Set a date for a meeting to review or close this investigation:

APPENDIX 5



Safeguarding Adults in Islington

Safeguarding Adults Case Conference/Protection Planning Meeting

The purpose of this meeting is:	
Case conference	<input type="checkbox"/>
Protection planning	<input type="checkbox"/>
Both case conference and protection planning	<input type="checkbox"/>
1. Client's initials: Date of Birth:	
2. Circulation of reports. (Where possible this should be done before the meeting, but if not, time to be allowed to read at the meeting).	
3. Attendance sheet and statement of confidentiality completed and signed (see attached):	
4. Introductions:	
5. Details about alleged incident/allegation and any other relevant information:	
6. Summary of investigation activity to date:	
7. What are the views and wishes of the client? If they are assessed as lacking the capacity to express their views or make decisions for themselves an appropriate family member, representative or advocate should have been consulted.	
8. Contributions of other representatives/agencies present at this meeting:	
9. Risk analysis/Protection planning: (please ensure any areas of disagreement are recorded). <ul style="list-style-type: none"> • On the balance of probabilities has abuse occurred? Yes/No If yes, what type of abuse? • Is there ongoing risk to the adult? Yes/No If yes, what is the risk? • Is there a need for a protection plan or amendment of an existing care plan? • Agree the Protection Plan. • Record all tasks, timescales, and names of individuals responsible for each task. • Communication. Agree how client/their representatives and the alleged perpetrator will be notified of decisions if they are not present. • Review of Protection Plan. Set a date for a review and agree what format the review will take. 	

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APPENDIX 6

Whistle-blowing Guidance for Managers of Social Services

For further information, and the guide for Social Services Employees please contact Employee Relations Officer on 020 7527 2802.

1. Introduction
1.1 These guidelines should be read in conjunction with the Whistleblowing Policy.
2. Council Commitment
2.1 In accordance with the Public Information Disclosure Act 1998 the council gives a commitment that any person making a 'Whistleblowing' complaint will not be subject to any penalty providing the complaint has been made in good faith.
3. Information for whistleblowers
3.1 Managers should draw the following information to the attention of any Whistleblower.
3.2 The Whistleblower should be referred to the complementary document: Whistleblowing - 'Guidance for Employees' which is available on the Human Resources Intranet site.
3.3 In furtherance of this commitment the council has sponsored the free telephone hotline provided by 'Public Concern at Work' which is an independent national organisation. This provides for employees to have free access to confidential legal advice relating to 'malpractice' and 'Whistleblowing'.
3.4 The Public Concern at Work 'Free Help Line' telephone number is 0207 404 6609. It also offers general advice on its website www.pcaw.co.uk
4. Scope of procedure
4.1 Managers should note that the scope of the protection covered in this procedure does not apply to personal complaints. There is a separate Complaints Procedure where the basis of the complaint relates to decisions or behaviour of the complainant's manager and or other employees.
5. Who is protected?
5.1 This policy is available to those who work for the council including: <ul style="list-style-type: none">• Employees• other workers (including volunteers)• trainees• agency staff• homeworkers• employees of contracting organisations may also use this procedure if they wish to raise malpractice issues.
6. What is malpractice?
6.1 Concerns about malpractice may in this context include a reasonable belief that one or more of the following has occurred, is occurring or is likely to occur: <ul style="list-style-type: none">• crime (including any form of child abuse, or the abuse of other vulnerable clients)• failure to comply with any legal duty (including negligence, breach of contract, breach of administrative law)

- miscarriage of justice
- danger to health and safety
- damage to the environment
- concealment of any of the above

7. What do I do if I receive a whistleblowing complaint?

- 7.1 Whistleblowing complaints must be treated seriously and your response must be immediate.
- 7.2 Whether or not the complaint is made orally or in writing you should make a note of the name of the complainant, the date of the complaint and the main substance of the complaint.
- 7.3 You should assure the complainant that the matter will be dealt with urgently.
- 7.4 You must immediately inform your Director of Service.

8. Director's responsibility

- 8.1 Directors who have a Whistleblowing complaint referred to them by a line manager or who receive the complaint personally must immediately (within 24 hours) inform the monitoring officer i.e. the Director of Law and Public Services who is responsible for monitoring such complaints and reporting to the Chief Executive and the Standards Committee.
- 8.2 Where the complaint relates to any financial impropriety you should also refer the matter to the Director of Finance.
- 8.3 You must appoint a senior and experienced officer to investigate the complaint and where possible aim for the matter to be concluded within 10 working days.
- 8.4 You must acknowledge in writing to the complainant that you have received the complaint and set out your proposed course of action and in particular setting out how you will keep the Whistleblower updated on progress.

9. Conducting the investigation

- 9.1 There are no special requirements for the conduct of the investigation other than time limits should be strictly observed (where the complexity of the case permits there should be a conclusion within 10 working days).
- 9.2 For guidance on how to conduct an investigation, Managers should refer to the Performance Management procedure on Discipline and Criminal Convictions.

10. Role of the Assistant Director of Customer Focus (Human Resources)

- 10.1 Where the complainant believes that it would be inappropriate to report the concern to his/her line manager/Head of Service he/she may report the malpractice to the Assistant Director of Customer Focus (Human Resources).
- 10.2 The Assistant Director of Customer Focus (Human resources) will inform the Monitoring Officer and (depending upon the circumstances) refer the matter to the Director of the complainant's service for an investigation to be commenced.
- 10.3 However, where the independence of the Director of that Service is a subject of the complaint the Assistant Director of Customer Focus (Human Resources) will in conjunction with the Chief Executive agree for an independent manager to take responsibility for conducting the investigation.

11. Role of Monitoring Officer

- 11.1 Where a complainant is dissatisfied with the actions by his/her Head of Service and or the

<p>Assistant Director of Customer Focus (Human Resources) the Monitoring Officer in conjunction with the Chief Executive will arrange for the matter to be dealt with as appropriate.</p> <p>11.2 The Monitoring Officer has responsibility for collating information relating to the number and conduct of investigations arising from Whistleblowing complaints.</p> <p>11.3 The Monitoring Officer will:</p> <ul style="list-style-type: none"> • Maintain a register of complaints including the date of receipt and the outcomes. • Keep the Chief Executive informed of the implications of new complaints; • Report regularly to the Standards Committee on the number and implications of Whistleblowing complaints reported.
<p>12. Role of the Chief Executive</p>
<p>12.1 The Chief Executive has overall responsibility for upholding the highest public standards in Islington. The Chief Executive will take immediate steps to ensure that concerns are being dealt with appropriately.</p>
<p>13. Standards and bad faith</p>
<p>13.1 The disclosure must be made in good faith, based on a reasonable belief that the information tends to show the specified malpractice. If however, a false allegation is made maliciously, disciplinary action may be taken. In such cases managers must be sure that the complainant was not simply mistaken. Where it appears that the complaint was made maliciously the manager should refer to the Performance Management Procedures on Disciplinary and Criminal Convictions.</p>
<p>14. Manager's responsibility to keep complainant informed of progress</p>
<p>14.1 As far as possible, the council will keep the employee informed of the decisions taken and the outcome of any enquiries and investigations carried out. However, the council will not be able to inform the employee of any matters that would infringe the duty of confidentiality owed to others.</p>
<p>15. Employee guaranteed safeguard</p>
<p>15.1 The council is committed to this policy. If an employee uses this policy to raise a genuine concern the council gives the employee an assurance that he/she will not suffer any form of retribution, victimisation or detriment. The council will treat the concern seriously and act according to this policy. The employee will not be asked to prove anything. The employee will be given feedback on any investigation.</p>
<p>16. Related documents</p>
<ul style="list-style-type: none"> • Whistleblowing Policy • Guidance for employees

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APPENDIX 7 - Key Telephone Numbers

This appendix only includes initial contact numbers relevant to the specific procedures for the assessment/investigation of alleged abuse. There is a comprehensive Directory of Services attached to the Community Care Plan which gives the telephone numbers of all statutory and voluntary organisations in Islington with a brief description of what they do. Many of these organisations have a vital role to play in protecting vulnerable adults.

1. Social Services	
Address	Tel/Fax/Email
Information and Access Team: 57 Calshot Street N1 9XH This is the first point of contact. This team takes initial details and refers on to the most appropriate team.	020 7527 2299
	Safe-Haven Fax: 020 7527 5114 The fax can receive Alerts from outside Social Services
	access.service@islington.gov.uk
Emergency Duty SW Team 5pm – 9am weekdays, 24 hours at weekends and Bank Holidays	020 7226 0992
Archway Community Care Centre North Locality Adults 4 Vorley Road N19 5JH	020 7527 7500 020 7527 7507 (fax)
Calshot Community Care Centre South Locality Adults 57 Calshot Street N1 9XH	020 7527 6400 020 7527 6407(fax)
Canonbury Community Care Centre Mental Health Services 68 Halliford Street N1 3RH	020 3317 4850 020 7527 8207(fax) CMHT only accepts referrals from GPs
Drayton Park & Archway Community Mental Health Team 1 Lowther Road N7 8US	020 3317 6370 020 7690 3519 (fax – Drayton Park CMHT) 020 7690 3516 (fax – Archway CMHT) CMHT only accepts referrals from GPs
Elthorne Community Care Centre Mental Health Services 17-23 Beaumont Rise N19 3AX	020 7527 7300 020 7527 7307(fax) CMHT only accepts referrals from GPs
Learning Disabilities Service Islington Learning Disabilities Partnership 52 ^d Drayton Park N5 1NS	020 7527 6600 020 7527 6607(fax)

Sensory Team & BSL interpreting team
23-26 St Albans Place
N1 0NX

020 7527 4443
020 7527 3279 (fax)
020 7527 3282 (minicom)

Whittington Hospital Social Work Team Ward MB3 Highgate Hill N19 5NF	020 7288 5260 020 7288 5262(fax)
2. Police	
Islington Police Station 2 Tolpuddle Street, N1 0YY	0300 123 1212 Central Switchboard
Community Safety Team / Officer	020 7421 0174
http://cms.met.police.uk/met/boroughs/islington/06advice_and_support/community_safety_unit_csu http://www.met.police.uk/reporting_crime/index.htm	
3. Inspection	
Care Quality Commission Finsbury Tower 103 – 105 Bunhill Row London EC1Y 8TG	Helpline 03000 616161
4. Independent Safeguarding Authority	
PO Box 181 Darlington DL3 9FA (for referrals to the Employment Barring list)	Helpline: 0300 123 1111 info@vbs-info.org.uk
5. For Advice	
Safeguarding Adults Development Manager Safeguarding Adults Administrator Islington Council/NHS Islington 338-346 Goswell Road, London EC1V 7LQ	020 7527 8160 020 7527 8162
Safeguarding Training Courses Rachel Adelson-Kettle	020 7527 8883

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APPENDIX 8

LIST OF CONTACTS TO SUPPORT VICTIMS OF ABUSE

Local

Islington Victim Support www.vslondon.org
 1 Highbury Crescent
 London
 N5 1RN

Helpline: 0845 303 0990 (24 hours)
 or 020 7700 6014

vs.islington@vslondon.org

Independent Mental Capacity Advocate (IMCA)
 Advocacy Partners

0845 0175198

Domestic Violence

Home Safe (children & families)

020 7527 5778

Independent Domestic Violence Advocacy Service
 (for professionals only 10-4 Mon –Fri)

020 7281 9284

Women's Aid

advice and support following violence

020 8269 2121

Single Homeless Project

referral line: 020 7520 8660
 client support line: 0800 783 8993

Criminal Injuries Compensation Authority (CICA)
www.cica.gov.uk

(claims) 020 7842 6800

Women's Therapy Centre
 (individual & group psychotherapy)

020 7263 6200

Women's Alcohol Centre

020 7272 8214

National

for victims

Voice UK (for people with learning disabilities)

0845 1228695

Criminal Injuries Compensation Authority

0800 358 3601

Domestic Violence (24 hour)

0808 2000247

Men's Advice Line & Enquiries

0845 0646800

Women's Aid Federation (24 hour)

0808 2000247

Rights of Women

(legal advice on relationship breakdown)

0116 255 6234

Samaritans www.samaritans.org

0845 790 9090

for agencies

Resource Information Service

(hostel advice to agencies)

020 7939 0641

Forced Marriage Unit British Nationals

020 7008 0151

Respond

support & training for professionals/families of victims
who have a learning disability

020 7383 0700

for perpetrators

Respect

help to perpetrators of domestic violence

0845 122 8609

Respond

for victims or perpetrators of sexual abuse & other
trauma, who have learning disabilities

Helpline: 0808 808 0700

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APPENDIX 9 SAFEGUARDING ADULTS – QUICK GUIDE FOR STAFF

What is 'Safeguarding Adults'?

'Safeguarding Adults' means making sure that vulnerable adults live free from abuse and neglect. This used to be called 'Adult Protection'. Everyone working in public services has a responsibility to report suspicions or allegations of abuse.

Who is a vulnerable adult?

A 'vulnerable adult' is someone who is 18 years or over who may be in need of community care. As a result of their mental or other disability, age or illness, they will find it difficult to protect themselves from abuse.

What is abuse?

There are many different types of abuse; some examples are:

- Physical
- Sexual
- Emotional/psychological
- Financial/material
- Neglect/acts of omission
- Discriminatory
- Institutional
-

Lots of different people may abuse vulnerable adults; some examples are:

- People who deliberately target vulnerable people
- Members of the vulnerable adult's own family and friends
- People who are employed to care for vulnerable adults

Sometimes people are not actually aware that they are abusing someone. Carers of vulnerable adults may become abusive because they are stressed and tired. It is still important that you report these situations, as Social Services can help to reduce pressure on stressed carers.

What are the signs of abuse?

There are many signs of abuse – ask if you are not sure! Some examples are:

- The person looks dirty or is not dressed properly
- The person never seems to have money
- The person has an injury that is difficult to explain
- The person seems frightened
- The person seems unusually down or withdrawn

There may be other explanations but these are often signs of abuse and you can't ignore them.

Do you suspect abuse? Tell us now.

Islington Adult Social Services Access Service

Tel: 020 7527 2299 | Email: access.service@islington.gov.uk | Fax: 020 7527 5114

What should I do if I suspect abuse?

- If there is a risk of immediate harm to the vulnerable adult and/or others:
 - Take yourself out of danger
 - Call 999
- If there is no immediate risk but you think abuse or neglect may be a problem:
 - Call the Social Services Access Service (details below)
- If you think another colleague or professional person is abusing a vulnerable adult:
 - Report this to your line manager.
 - If you are unhappy with their response or do not feel you can approach them then call the Social Services Access Service (details below).
 - You might feel worried about reporting your colleagues. Remember that it is difficult for vulnerable people to report abuse and they rely on you to help them.

What happens next?

- We (Adult Social Services) gather information and undertake a risk assessment. We take any immediate action we can to protect the person from further abuse.
- If there is a possible criminal offence, we consult the police. The police decide whether they will lead an investigation or not.
- If the police decide not to investigate, we decide whether or not we need to do an investigation. We talk to the person suspected of being abused. If they do not have the *capacity* to understand what is happening or to protect themselves, a representative or independent advocate can act for them.
- If we decide it is not right to investigate then we talk to the vulnerable adult and those around them to help protect them from future harm. For example, we might arrange for a stressed carer to have some respite care.
- If we decide that abuse has, or may have, taken place a social worker or other professional leads an investigation. A 'strategy' meeting is held. Those involved agree how to go about the investigation and how much time it should take.
- Once the investigation is over, the findings are reported at another meeting called a 'case conference' or 'protection planning meeting'. A 'protection plan' is agreed and put in place for the vulnerable adult.
- Later on, the protection plan will be reviewed and any changes to it agreed and implemented. If no further action is needed the safeguarding process will end.

Do you suspect abuse? Tell us now.

Islington Adult Social Services Access Service

Tel: 020 7527 2299 | Email: access.service@islington.gov.uk | Fax: 020 7527 5114



Stage 1 (Alert – same day)

A man with cancer lives alone in supported housing. He tells the district nurse that the cleaner of the block of flats is not very nice and often shouts at him. The district nurse reports this to her line manager.

Stage 2 (Referral – same day)

The line manager calls the Social Services Access Service and passes on the information. The practitioner receiving the call records all details and finds that the service user is already known to the North Locality team. The practitioner calls the man's allocated worker and passes on details of the case. The allocated worker discusses the case with the service manager (acting as Safeguarding Adults Manager or SAM) who asks her to collect more information. The SAM contacts the line manager of the manager of the block of flats and reports the complaint against the cleaner.

Stage 3 (Decision – end of working day following alert)

The allocated worker reports back to the SAM with further information: the service user appears to have capacity and would like to have the case investigated. The SAM decides to proceed with an investigation.

Stage 4 (Strategy – end of fifth working day following referral)

The allocated worker, SAM and manager of the housing block attend the strategy meeting which takes place at the North Locality Team offices. They agree:

- The allocated worker should talk to other people living in the block to see if they have experienced similar abuse by the cleaner and/or other staff.
- The allocated worker should talk with the service user who raised the original concern in more detail and gain more information on times, dates and nature of the abuse.
- The allocated worker should contact the service user's family to see if changes in his behaviour have been perceived.
- The manager of the housing block reports that the provider organisation has decided to suspend the cleaner until the investigation is concluded.

Stage 5 (Investigation – four weeks from referral)

The allocated worker interviews other service users in the block and three of them report that the cleaner has also been unpleasant and shouted at them on occasion. However, all service users report that they are happy with other staff in the housing block, but that there is just a problem with this individual.

Stage 6 (Case Conference and Plan- four weeks from beginning of investigation)

The allocated worker, SAM, manager of the housing block and service user about whom the original alert was raised attend the case conference. They agree that on the balance of probabilities, the abuse did take place.

The manager of the housing block reports that the cleaner will be dismissed and reported to the Independent Safeguarding Authority.

The group draw up a protection plan for the service user which includes having one of the housing support officers present the first few times the new cleaner begins.

Stage 7 (Review - six months after plan)

Three months later the case conference group reconvene. The service user reports that he feels much happier and safer with the new cleaner. He also says that he knows who to contact if he does not feel safe with them. The group decide to close the safeguarding case.

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Example Two

Stage 1 & Stage 2 (Alert and Referral – same day)

The manager of a residential home for people with learning disabilities calls an ILDP allocated worker. She tells him that a 33-year-old female resident has been behaving out of character - incontinence and unusual use of words. Together these **might** indicate sexual abuse had taken place. The allocated worker reports this to the team manager (Safeguarding Adults Manager or SAM) who asks for more information to be gathered.

Stage 3 (Decision – by end of working day following alert)

The allocated worker and SAM agree that there is sufficient reason to proceed with a Safeguarding Adults investigation and they call a strategy meeting. The allocated worker confirms that the woman has a recent mental capacity assessment and is deemed not to have capacity. The SAM contacts the police for their advice on how to respond. The police ask to be kept informed of investigations.

Stage 4 (Strategy Meeting – by end of fifth working day following alert)

The strategy meeting takes place at the home and is attended by the allocated worker, SAM, home manager and key worker. They agree that:

- The key worker should make sure that an up-to-date mental capacity assessment was on the service user's record. The service user was thought to lack capacity to understand what sexual abuse would mean, but would be able to indicate when she was happy or not happy about events or situations.
- A medical examination was thought to be unnecessarily intrusive (and possibly abusive), but that a pregnancy check and details of periods would be useful.
- The home manager reported that the woman was not exhibiting this behaviour prior to the previous weekend when she had a visit from her family who took her out for the day. The

group recognised the need to consider whether someone in the family might be responsible for the abuse. They agree that the allocated worker should look at staff records and interview staff for their observations of the service user's interactions with her family.

- The allocated worker should look at staff records and interview staff in relation to the service user's behaviour and care generally

Stage 5 (Investigation – four weeks from referral)

Actions agreed in the strategy meeting were undertaken.

Stage 6 (Case Conference and Plan - four weeks from beginning of investigation)

A case conference and protection planning was held at the home, attended by the allocated worker, Safeguarding Manager, Home manager, key worker and the service user.

The home manager and the key worker reported that the unusual behaviour had not happened again. The allocated worker reported the service user's only relatives were the woman's mother and aunt, both in their sixties. All records and verbal reports from Social Services and the home gave a consistent account of two very caring and supportive relatives who visit regularly and always take the service user out for the day. The allocated worker had spoken to the relatives about the day in question. The mother and aunt explained that there had been a problem when they had taken her out for the day – she had been scared by a ride they had taken her on.

The case conference group agree that on the balance of probability it was unlikely the resident had been abused. However, the group felt that the case had highlighted ways in which staff might prevent abuse happening in the future. Therefore, a safeguarding plan was drawn up.

Stage 7 (Review – six months after plan)

The group met six months later. All reported that the resident had not displayed any more unusual behaviour. The group decided to build the specific safeguarding actions into the resident's care plan and close the safeguarding case.

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Example Three

Stage 1 (Alert – same day)

A man aged 82 is admitted to hospital with unexplained facial injuries and evidence of older injuries. He discloses to one of the nurses that he is being physically, emotionally and financially abused by a relative who lives with him. The nurse tells the patient that she must report this to her line manager. The nurse reports this to his line manager.

Stage 2 & Stage 3 (Referral & Decision - by end of working day following alert)

The nurse's line manager calls the 'Social Services Access Service' and tells them about the reported abuse. The practitioner receiving the call records all details and finds that the service user is already known to the 'MHCOP' Team (Mental Health Care of Older People). The practitioner calls the MHCOP Team and passes on details of the case.

MHCOP Practitioner receiving the case discusses details with their team manager (Safeguarding Adults Manager or SAM). Practitioner confirms that the man has given consent for the police to be contacted. The SAM alerts the police immediately. As the case is deemed an emergency the SAM and allocated worker agree that a safeguarding strategy involving all partners needs to happen immediately.

Stage 4 (Strategy - within five working days)

Due to the urgency of the situation, the Strategy Meeting is convened on the same day. The Safeguarding Manager, MHCOP Practitioner, Staff Nurse from the Ward and Police Officer attend. They agree the following actions:

- Police confirmed they would undertake the investigation and would need details of the man's injuries.
- Staff nurse confirms there are no plans for discharge at present. Agreed that discharge would not take place until this was deemed safe.

Case conference date was set to review progress and outcomes.

Stage 5 (Investigation – within four weeks of referral)

The police investigation finds evidence that the man's account was correct. There were a number of injuries and large sums had been taken from the man's bank account. The relative is charged with a number of offences.

Stage 6 (Case Conference/Protection planning meeting – four weeks of start of investigation)

A case conference is held at the hospital so the man could attend. The SAM, MHCOP practitioner, ward staff nurse and police officer attend. The Police update the group on the findings of the investigation. The man expresses his wish to return home. He is anxious that the relative was not able to return to his home.

A safeguarding plan is put in place, which includes:

1. An injunction to prevent the relative from going near his home.
2. A pendant alarm system installed
3. A discharge plan with support package
4. Man given information on where to get help if needed in the future

Stage 7 (Review – six months after plan)

The case conference group meet again to review the effectiveness of the safeguarding plan. The service user reports that he feels much safer and happier now that the relative has been arrested and left his home. The group decide not to close the case though, as the trial is still pending.

The trial happens and the relative is imprisoned for two years. The group decide to keep the safeguarding case open until after the relative has been released. This is to make sure that safeguards continue to be in place after this release.

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APPENDIX 11

LEGAL ADVICE ON USE OF PHOTOGRAPHIC EVIDENCE

In all cases, decision making should emphasise what is in the best interests of an individual. If a person cannot make a particular decision for him/herself, speaking to a family member or the use of an advocate in their absence should be considered.

1. Receipt of photos

If presented with any photographic evidence, staff members are not responsible to check re consent of the person pictured (or the consent of their relatives).

The legal recommendation is to keep all photos on file or keep an electronic record of what they have received. The issue of confidentiality is not to disclose onwards these photos. If request made to return photos, a copy should be kept in case it is later required for a court hearing.

There is a need to disclose to relatives of the injured client any known facts, as would be the case with any investigation, and which may include the use of photographs. The exceptions to this are where there is a police enquiry and this is contra-indicated, or the relative is implicated in any injury/incident regarding the alert.

2. Taking of photos

As a general rule, there should not be discouragement in photos being taken of injuries or of poor practice - by family or staff (as is backed up by a recent Serious Case Review). Any person taking photos should formulate in their own mind the purpose of taking them and the issue of consent. It is acknowledged that this is not easy for a lay person to do.

Any Social Worker involved in investigation may be required to have a photo taken of injuries in a criminal case & should arrange for this to take place in a medical examination. It is recommended they only do this themselves, or request it is done by someone who knows the person well, unless to do so would result in a time delay and evidence may be lost (for example bruising fades within a few days or a week).

3. A cautionary note

Overt video camera is acceptable in public spaces to catch any incident - as long as it is made clear that it is in use. It is more complicated if covert cameras are suggested to find out what is happening. It may be acceptable to use covert cameras if there are no allegations regarding a specific person. However some difficulties may arise where the recording made be seen as intrusive, or the purpose of taking photo may be considered part of the abuse (for example watching & not preventing abuse occurring).

It would be a very questionable practice to put camera in person bedroom. No photos should be taken of any private part of the body except as a result of a medical examination.

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APPENDIX 12

PROCEDURE FOR SERIOUS CASE REVIEW (SCR)

1. Introduction

The document 'No Secrets' (March 2000) issued by DH and Home Office under section 7 of the Local Authority Social Services Act 1970, gave guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.

The guidance states that local agencies should collaborate and work together to achieve effective inter-agency working, through the formation of multi-agency management committee's (MAMC's) also known as Safeguarding Adults Partnership Boards (SAPB's).

The document Safeguarding Adults published by Association of Directors for Social Services (ADASS) published in October 2005 provides a National Framework of Standards for good practice and outcomes in adult protection work. One of the standards in this document states that each SAPB or MAMC as a matter of good practice should aim to have in place a serious case review protocol.

All agencies have their own internal/statutory review procedures to investigate serious incidents (for example an Untoward Incident). This protocol is not intended to duplicate or replace them. A SCR would be considered after the usual internal procedures for partnership organisations had been followed and serious outstanding adult protection concerns were uncovered.

The purpose of this document is:

- To provide guidance to Islington's Multi-Agency Management Committee – Adult Protection/Safeguarding Adults Partnership Board (SAPB)
- To facilitate development in a consistent approach to the process and practice in undertaking a serious case review

2. Relevant Standards

Standard 1.22 of the ADASS National Standards states the following:

There is a 'Safeguarding Adults' serious case review protocol. This is agreed, on a multi-agency basis and endorsed by the Coroner's Office, and details the circumstances in which a serious case review will be undertaken. For example: when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults. The links between this protocol and a domestic violence homicide review should be clear.

3. The Purpose of Serious Case Reviews

The purpose of the case review is not an enquiry into how the death or serious incident occurred, and if an allegation is found to be true, who is to blame. Any such matter is dealt with via the Coroner's or Criminal Courts. It is to:

- Establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard vulnerable adults
- Review the effectiveness of the adult protection and internal agency procedures
- Inform and improve local inter-agency practice
- Improve practice by acting on learning (developing best practice)
- Prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action
- To facilitate development in a consistent approach to the process and practice in undertaking

a serious case review

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4. Criteria for Serious Case Reviews

Consideration will be given for a serious case review when abuse or extreme neglect of an adult results in any of the following:

- Death of an adult (including suicide)
- Life threatening injury,
- Serious and permanent impairment to health caused through serious abuse, sexual abuse or neglect,
- When serious abuse takes place in an institution, or multiple abusers are involved,
- Cases giving rise to concerns about the way in which local professionals and services worked together to safeguard vulnerable adults.

5. Deciding factors

In deciding whether a case review should take place other than when an adult has died, this set of criteria questions should be considered. A 'yes' answer to several of these questions is likely to indicate that a review will yield useful lessons:

- Was there clear evidence of risk or significant harm, which was not recognised by agencies in contact with the vulnerable adult or perpetrator, or not shared with others or not acted upon appropriately?
- Did the abuse occur in an institutional setting?
- Does one or more agency feel that its concerns were not taken seriously or acted upon by another?
- Does the case indicate that there are failings in the formal protection procedures that go beyond the handling of this case?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that there might need to be a change in local protocols or procedures, or that protocols and procedures are not being adequately promulgated or acted upon?

6. Commissioning and carrying out a serious case review

- The SAPB will be the only body in Islington which commissions any serious case review.
- Any application for a Serious Case Review should be put in writing to the Chair of the Islington SAPB. These would normally be from members of staff, but requests from the Coroner, MPs, and Elected Members will also be considered.
- In order for a review to be commissioned, it must attract the support of the quorum of the SAPB.
- The SAPB, or a Panel of its members, will produce the Terms of Reference under which the individual serious case review will be considered
- All applications will have a record of whatever the decision the SAPB, or a Panel of its members, reached with reasons why any application was rejected. This will then be sent to the applicant.

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7. Serious Case Review Panel

If the SAPB decides to commission a review, a multi agency Serious Case Review Panel will be set up and drawn from members of the SAPB and any additional nominees who have particular knowledge or can represent particular groups (for example informal carer, advocates).

- The Chair of the SAPB and the Chair of the SAPB Panel have the right to veto any nominated representative if they consider them inappropriate for the task.
- The Chair of the SAPB will be responsible for the appointment of an Independent Reviewing Officer and securing finances for this appointment. The Adult Protection Co-ordinator will provide a list of Reviewing Officers to consider. The person chosen must have experience of similar investigations and an understanding or expertise in working with the particular service user group. If there is no conflict of interests, the Reviewing Officer can be a senior manager of a partner organisation.
- The Chair of the SAPB will ensure the Independent Reviewing Officer receives adequate support to do the required tasks.
- The Chair of the SAPB will also Chair of the Reviewing Panel, or appoint a Chair from the members of the Panel. In some circumstances it may be appropriate for the Reviewing Officer to Chair the Panel. The Chair of the Reviewing Panel must work to the stated terms of reference and timescales produced by the SAPB but will in some cases need to discuss alterations. The SAPB will have the final say and can impose such additional terms of reference and timescales as it considers appropriate in the circumstances of the case. The SAPB and the SAPB Panel will also be responsible for ensuring administrative arrangements are completed and that the review process is conducted according to the terms of reference.

8. Serious Case Review-receipt of evidence

The SCR Panel is convened to consider the sharing of relevant information. All agencies will be encouraged to query and comment on the reports, which may be verbal, that are presented by all agencies with involvement in the case.

The Chair of the Panel is responsible for ensuring that the Reviewing Officer has access to relevant information from all services prior to this meeting. Following this meeting the Reviewing Officer will produce a summary of topics the final report will cover.

During the process of producing the report, the Independent Reviewing Officer must report back to the Chair of SAPB or the Chair of the Review Panel, any previously unknown information, and relevant decisions that need to be made during the course of the Review.

9. Report Stage

The review panel will complete the review of agency management reports and those commissioned from any other source, and will assist and advise the Chair on the production of an Overview Report, which brings together information, analyses findings and recommendations for future action.

On completion, the Overview Report will be presented to the SAPB, which will:

- Ensure contributing agencies are satisfied that their information is fully and fairly represented in the Overview Report or, if this cannot be achieved, that any areas of disagreement and the reasons for it are properly recorded.
- Ensure that the Overview Report contains an Executive Summary that can be distributed for the wider public
- Translate recommendations from the overview into an **action plan**, which must be endorsed at senior level by each agency
- Pass the action plan to the Serious Case Review Monitoring Group for review of implementation

10. The action plan will indicate:

- Who will be responsible for various actions
- Time-scales for completion of actions
- The intended outcome of the various actions and recommendations
- The means of monitoring and reviewing intended improvements in practice and/or systems
- Clarify to whom the report or parts of the report should be made available, and agree the means by which this will be carried out
- Disseminate the report or key findings to interested parties as agreed and provide feedback and debriefing to staff, family members and, where appropriate, the media

11. Recommendations

The SAPB will ensure that all recommendations are actioned and will request updates from agencies. The action plan will remain on the SAPB agenda until such time that all recommendations have been implemented.

The SAPB will include in its Annual Report, which will be distributed to members and stored on each agency's website, a report of the outcome of every SCR completed within that year and relevant details concerning the implementation of recommendations.

12. Other Considerations to Serious Case Review

- There will be a need to address the budgetary requirements for undertaking a serious case review
- There will be a need for a list of Independent Reviewing Officers available for such investigations, details of which will be available from the Adult Protection Co-ordinator
- The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the 'right to know', came into force in January 2005.
- There are 'absolute' and 'qualified' exemptions under the Act. Where information falls under 'absolute exemption', the harm to the public interest that would result from its disclosure is already established.
- If a public authority believes that the information is covered by a 'qualified exemption' or 'exception' it must apply the 'public interest test'.
- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it.
- There may be need for the completion and implementation of media and communication strategies.
- Due regard for criminal/civil process should be observed at all times.
- Arrangements to obtain or secure records through statutory agencies should be utilised whenever appropriate, e.g. Police, CSCI.
- Circumstances may arise whereby it is appropriate to carefully consider the manner in which a consultation with the victim of abuse or their relative should take place.

APPENDIX 13

SAFEGUARDING ADULTS IN ISLINGTON

ESTABLISHMENT CONCERNS PROCESS

Background information

The Establishment Concerns Process (ECP) is invoked to address serious concerns within an establishment. The threshold for an ECP is likely to be the occurrence of more than one serious incident involving more than one service user and/or more than one staff member within an establishment.

For the purposes of this process, an 'establishment' is defined as a provider of care to adults who are vulnerable. This can be a care home, hospital, supported accommodation or provider of care in the community

The definition of a 'serious incident' is an adult safeguarding incident where a service user or service users have suffered actual harm or sustained physical or psychological injury or financial or material loss which, on the basis of evidence has been caused by neglect or abuse.

Key stages

Stage 1: Decision to invoke the ECP

The decision to invoke the ECP will be taken by the Development Manager, Safeguarding Adults and the appropriate Assistant Director within Strategy and Commissioning.

The incidents affecting service users will be individually investigated in the usual way via the Safeguarding Adults procedures. This would include inviting the service user or their advocate/family member to attend a safeguarding meeting following the individual investigation, to determine actions required if abuse/neglect is substantiated. The findings (with a statement of probability as to what occurred in each case) must be fed back within an Establishment Concerns meeting.

Stage 2: Initial strategy meeting and notification

Once it has been agreed to invoke the ECP, a meeting will be called with relevant parties.

The establishment about which the concern has been raised will be notified in writing that the ECP has been invoked. They will be informed of the allegations at the earliest possible opportunity. If there is a Police investigation, they will be informed in accordance with Police advice.

The Development Manager Safeguarding Adults will inform the Care Quality Commission (CQC) that the ECP has been invoked, and the CQC will be invited to participate.

The initial strategy meeting will clarify roles and responsibilities, particularly:

- The chair (who will be responsible for coordinating all pieces of work within the process).
- The administrative support.
- The link worker for user/carer/relatives
- The lead responsible for drawing up terms of reference for the external investigation (if appropriate).
- Date of next and any subsequent meeting of the ECP.

Stage 3: Service user involvement

Service users or their advocates/family members will be invited to attend a safeguarding meeting following the individual investigation (see Stage 1 above) to determine what action is required once suspicion of abuse or neglect has been substantiated. Service users, their advocates/family members would not be invited to attend ECP meetings which will by nature involve discussion of potentially sensitive details about more than one individual service user or staff member. Accordingly it is important that information which relates to or identifies other service users is only shared on a 'need to know' basis using the Caldicott Principles as follows:

- Justify the purpose
- Do not use personally identifiable information unless it is absolutely necessary
- Use the minimum personally identifiable information
- Access to personally identifiable information on strict need to know basis
- Everyone should be aware of their responsibilities
- Understand and comply with the law.

Stage 4: Central file

One central shared file will be set up for each ECP investigation. This file will only be accessible by Council and NHS Islington staff involved in the specific ECP, with password protection shared only with participants. All minutes will record key decisions and agreed actions to be followed up at the next meeting.

Stage 5: Investigation and report

The ECP would be informed by the outcome of the individual Safeguarding Adults investigation or investigations (see guidance on the Safeguarding Adults investigation process), unless there are exceptional reasons for a further investigation to be undertaken. This minimises the repeated questioning of the vulnerable adults and witnesses (as per the National Framework for good practice and Outcomes in Adult Protection Work published by the ADSS).

Once the investigation report (or reports in the case of more than once investigation) is written, it will be presented to the ECP meeting and will form the basis of the discussion to agree an action plan to minimise the risks of future abuse or neglect within the establishment.

The ECP may need to take decisions or make recommendations for an action plan in advance of completion of investigations in order to address urgent concerns about vulnerable service users.

Should the ECP conclude that there is no cause for concern then this decision will be recorded and the establishment and CQC informed.

Stage 6: Implementation of the Action Plan in cases where abuse/neglect are established

Where there are issues to be addressed, the action plan will be agreed with involved parties/agencies (see Stage 5 above). The action plan will be monitored over an agreed period of time, with a final concluding statement issued that will record the progress of the establishment to reach the required standard, or the need for any alternative actions that have been undertaken. This statement should be taken to Housing and Adult Social Services Senior Management Team or NHS Islington Senior Management Team for sign-off.

Stage 7: Concluding Statement

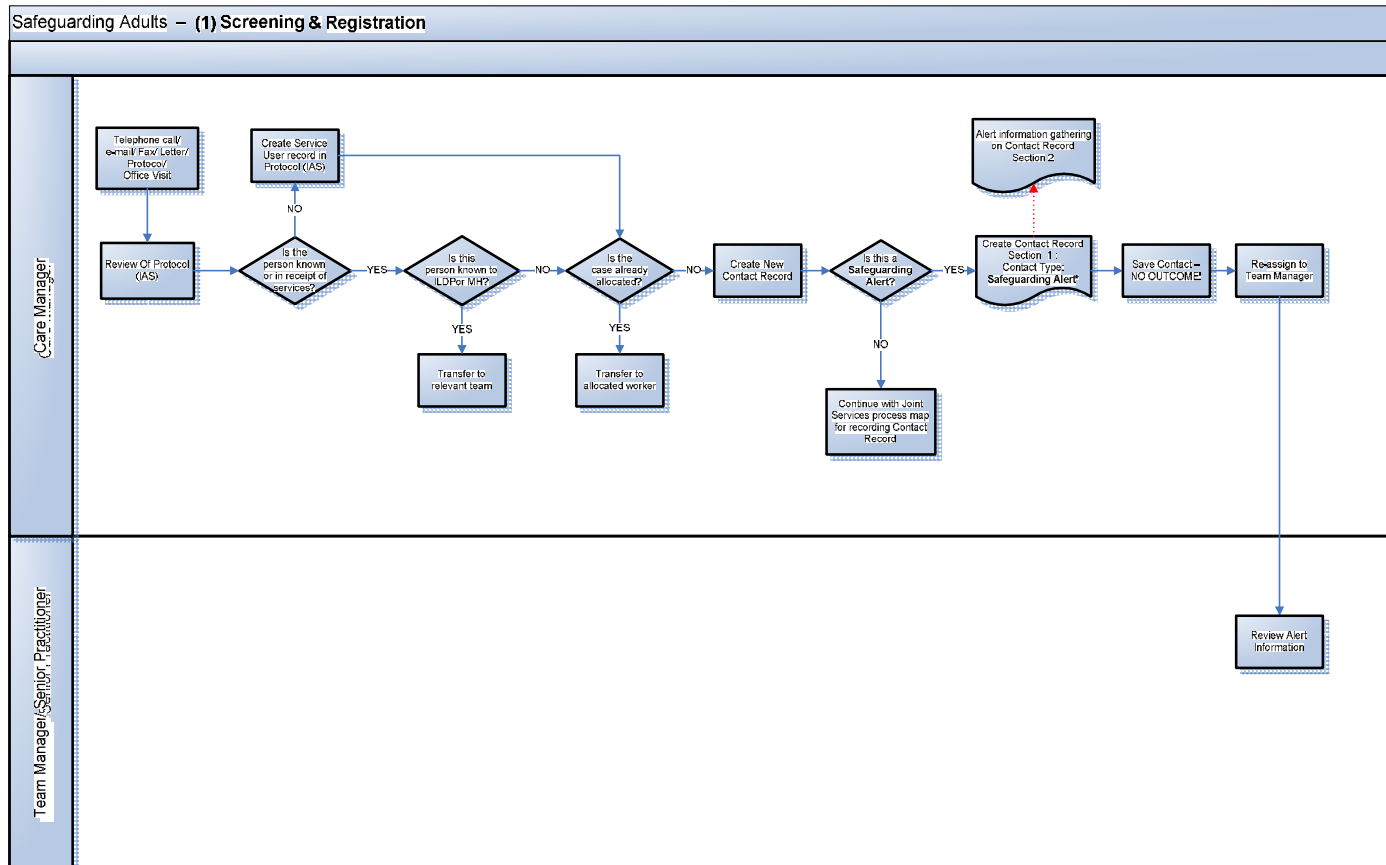
At the point of writing the concluding statement (see Stage 6 above) at the end of an ECP the group will review actions that have been taken and lessons learnt that will be included in a Summary Report to the Quality, Audit and Assurance sub group of the Islington Safeguarding Adults Partnership Board and the appropriate Senior Management Team.

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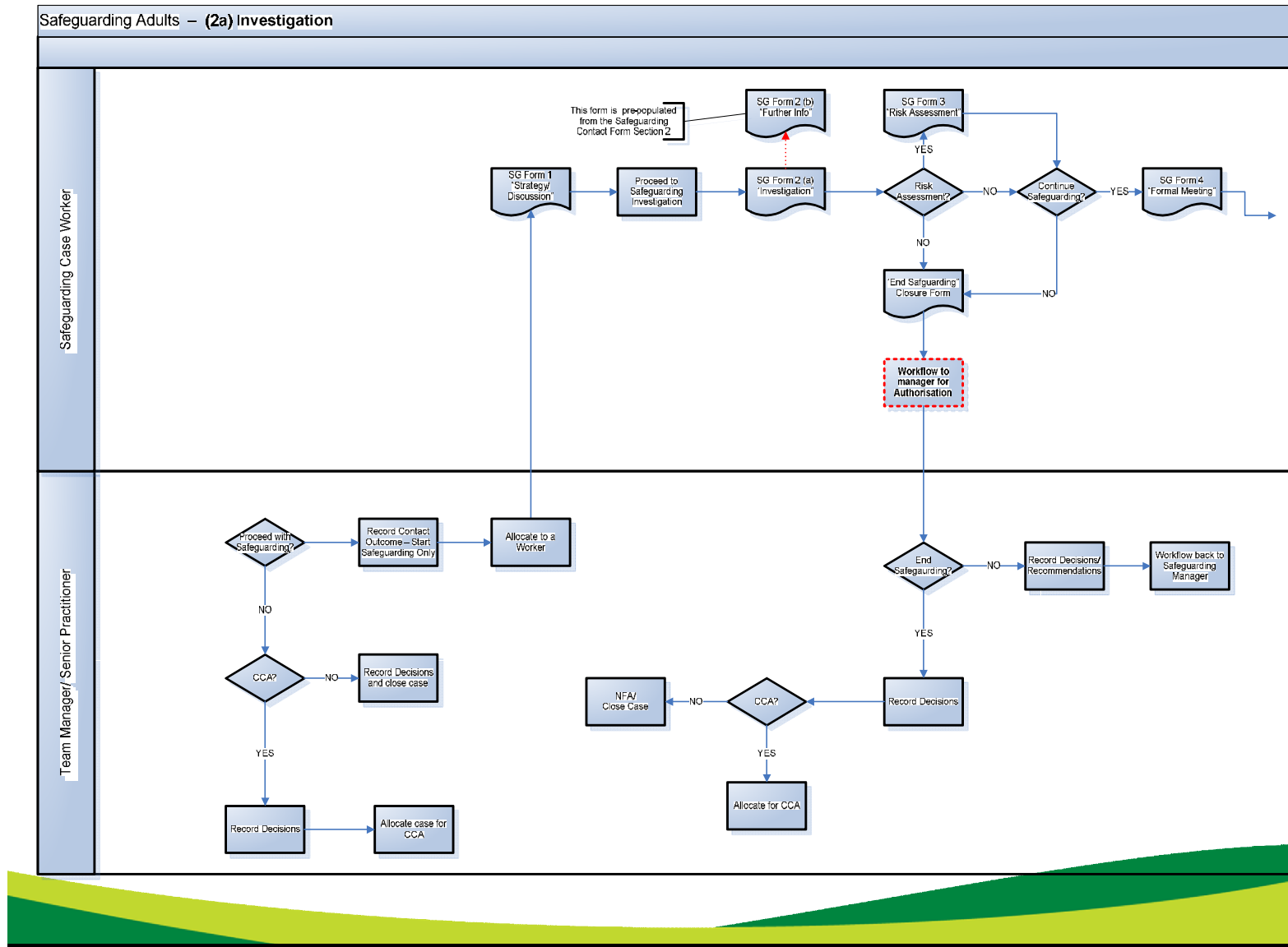
APPENDIX 14

SAFEGUARDING – IAS FLOWCHART

1. Screening & Registration



2 (a) – Investigation



2 (b) Investigation

