Enquiries to: **Information Team**
Our Ref: **FOI 516307**

Liverpool City Council

request-382827-5fb69d6a@whatdotheyknow.com

Dear Mr Barton

Freedom of Information Request 516307

Thank you for your recent request received 20 January 2017. Your request was actioned under the Freedom of Information Act 2000 in which you requested the following information –

> *"Please can you provide a copy of the authority's policy or policies which detail the legal responsibilities and safeguarding procedures that are in place when the local authority are an appointee for an individual and what information is provided to support providers in order to assist in money management for people who lack capacity."*

Response:

Liverpool City Council can advise that the attached documents and letters refer to the information currently in place. The Deputy standards document attached is for reference but this and other documentation is published at the following location https://www.gov.uk/government/publications/local-authority-deputyship-responsibilities

This concludes our response.

The City Council will consider appeals, referrals or complaints in respect of your Freedom of Information Act 2000 and you must submit these in writing to Informationrequests@liverpool.gov.uk within 28 days of receiving your response.

The matter will be dealt with by an officer who was not previously involved with the response and we will look to provide a response within 40 days. If you remain dissatisfied you may also apply to the Information Commissioner for a decision about whether the request for information has been dealt with in accordance with the Freedom of Information Act 2000.

The Information Commissioner's website is www.ico.gov.uk and the postal address and telephone numbers are:-

Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF. Fax number 01625 524 510, DX 20819, Telephone 01625 545745. Email – mail@ico.gsi.gov.uk (they advise that their email is not secure)

I trust this information satisfies your enquiry.

Yours sincerely

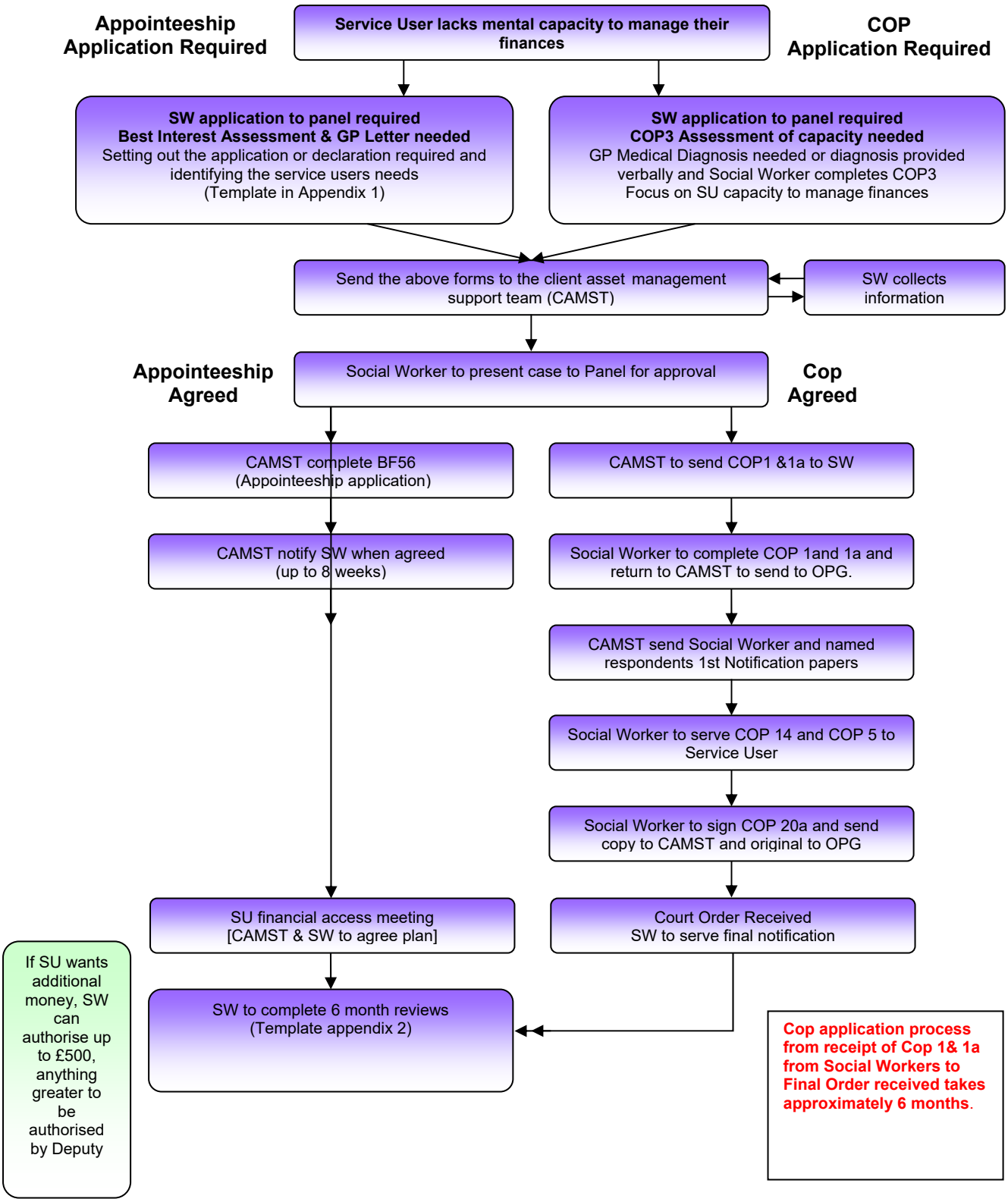
A Lewis

Angela Lewis
Information Team
Enc.

Liverpool City Council Information Team
Cunard Building, Water Street, Liverpool, L3 1DS
E: informationrequests@liverpool.gov.uk

Court of Protection Operational Guidance for Social Workers

COP Forms:
http://www.direct.gov.uk/en/Governmentcitizensandrights/Mentalcapacityandthelaw/UsingtheCourtofProtection/DG_176444



The Mental Capacity Act 2005 dictates that people who lack mental capacity should be assisted as much as possible to make their own decisions, but in situations where a person is proven unable to make decisions a Legal Power of Attorney (LPA) or pre-existing Enduring Power of Attorney (EPA) [prior to 1st October 2007] can assist or make decisions on that persons behalf.

No EPA or LPA

An application for LPA would typically be sought by a family member, friend or legal representative of the person who has difficulty making decisions.

In situations where a representative (either EPA or LPA) does not exist or is unsuitable for the responsibility that would be assigned to them; Liverpool City Council (LCC) can make an application for these legal rights.

There are two options available:

Appointeeship *- when a person's income comprises of only welfare benefits, and a state pension Liverpool City Council would apply to the Department of Work and Pensions to be made an appointee for the service user.*

Therefore an appointee is responsible for claiming the benefits and notifying the Department of Work and Pensions of any change in circumstances. The appointee cannot deal with any capital or with any income derived from sources other than benefits.

The Department of Works and Pensions or the Council may terminate the appointeeship at any time, and the service user may end the arrangement if they regain capacity to manage the benefits payments themselves.

Deputyship *– when a person has property and assets exceeding £2000 or requires decisions to be made about their personal welfare Liverpool City Council could apply to the Court of Protection to be made a deputy for the service user.*

A Deputy has the power to make financial decisions on behalf of the person lacking capacity to do so, but the powers of a Deputy are subject to restrictions imposed by legislation and to any restrictions imposed by the Court in the form of a Court Order.

The responsibilities are the same as that of appointeeship but will extend to the consolidation of financial assets on receivership of a Court Order.

Liverpool City Council

01 March 2017

Dear Sir/Madam

Re:

Liverpool City Council have been appointed Deputy by the Court of Protection to manage the property and affairs for the above named, please find enclosed a copy of the court order for your records.

Management of the finances will be the responsibility of the Client Asset Management Support Team (CAMST) acting with delegated responsibility from the Court appointed Deputy.

The Client Asset Management Support Team will be responsible for facilitating agreed payments on behalf of …….. Regular payments will be agreed at the set-up meeting and are authorised by the Social Worker.

Any additional requests for expenses need to be submitted to the Social Worker for consideration and approval, once approved the request is sent to CAMST to facilitate payment. Please note requests for larger sums of expenditure (over £500) also require Deputy approval. All requests for expenditure of large sums require 3 quotes.

You are required to maintain records of all sundry accounts for audit purposes and receipts for all items of expenditure, and will be reviewed by an Officer of Liverpool City Council on a six monthly basis.

If you require any further clarification please contact myself, as I am the COP Officer assigned to this case.

Yours faithfully

……
Court of Protection Officer

Liverpool City Council
Municipal Buildings, Dale Street, Liverpool, L2 2DH
T: 0151 233 0777
E: CAMST@liverpool.gov.uk liverpool.gov.uk

Liverpool Safeguarding Adults Board

Inter-agency safeguarding adults policy and procedures


Liverpool
City Council


NHS
Liverpool
Clinical Commissioning Group


Citysafe
LIVERPOOL A SAFE CITY


NHS
England


Mersey Care
NHS
NHS Trust


Aintree University Hospitals
NHS
NHS Foundation Trust


LIVERPOOL SAFEGUARDING CHILDREN'S BOARD
LSCB


healthwatch
Liverpool


Where quality matters


The Royal Liverpool and
Broadgreen University Hospitals
NHS
NHS Trust


G4S


fighting crime
protecting communities


Liverpool Community Health
NHS
NHS Trust


Community
first


Community
Integrated
Care


LMC


Merseyside
FIRE & RESCUE
SERVICE


Merseyside
Community Rehabilitation Company
PROBATION


Liverpool Women's
NHS Foundation Trust


LHT


MCJA


The Walton Centre
NHS
NHS Foundation Trust


Liverpool
Community
College


Liverpool Social Care Partnership

Information Sheet

Title	**Liverpool Safeguarding Adults Board (LSAB) Inter-agency safeguarding policy and procedures for safeguarding adults at risk of abuse or neglect**
Responsible Officer	**Jan Summerville**
Director Responsible	**Samih Kalakeche/Jane Lunt**
Ratified By	**SAB/SMT**
Ratification date	**29/09/2015 28/10/2015**
Implementation date	
Review Period	**Annual**
Review Date	
Version Updates	**V3 October 2015**
Responsible Group	**Liverpool Safeguarding Adults Board Policy and Procedure Sub-Group**

Please note that the intranet version of this document is the only version that is maintained. Any printed versions should therefore be viewed as 'uncontrollable' and may not be the most up-to-date

This document will be made available in different formats upon request. Please contact:

Jan Summerville
0151 233 0809

Email: Jan.summerville@liverpool.gov.uk

Letter from the co-chairs of Liverpool's Safeguarding Adults Board

Dear colleagues,

Welcome to Liverpool's safeguarding adults policy and procedure.

We have recently been reviewing and updating the safeguarding adults procedures to reflect the Care Act 2014 which came into force on 1 April 2015. The Care Act is the first statutory framework for safeguarding adults at risk of abuse or neglect.

The principle that underlies the Care Act is that of promoting the wellbeing of individuals, and of making sure that professionals always recognise that each person's needs are different, and respond accordingly. The Care Act makes it very clear that it is the person not the process that determines how safeguarding is taken forward by professionals.

We are committed to promoting the wellbeing of adults and preventing abuse and neglect. When abuse does take place it will be dealt with swiftly, effectively and in ways which are proportionate to the issues that have been identified with the person's chosen outcomes at the heart of safeguarding.

This policy and procedures explains how agencies and individuals will work together to support and safeguard adults with care and support needs who are experiencing, or at risk of, abuse or neglect and as a result are unable to protect themselves.

We would welcome your comments on this document. Contact details can be found on the information sheet at the front of this document.

Samih Kalakeche

Liverpool Safeguarding Adults Board

Director, Adult Services and Health
Liverpool City Council

Jane Lunt

Liverpool Safeguarding Adults Board

Head of Quality/Chief Nurse
Liverpool Clinical Commissioning Group

Contents page

Part 1 Policy and guidance

1. Introduction

The Care Act 2014 sets a clear framework for how local authorities should protect adults at risk of abuse or neglect. The Act places a duty on local authorities to make enquiries, or cause others to do so, if it believes that an adult:

- has needs for care and support (whether or not the authority is meeting those needs) and
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or the neglect or the risk of it.

The purpose of the enquiry is to establish whether any action needs to be taken to stop or prevent abuse or neglect and if so by whom.

1.1 Aims of the adult safeguarding policy

This policy and procedure aim to:

- raise public awareness so that communities as a whole, alongside professionals, play their part in identifying and preventing abuse and neglect
- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or wellbeing of an adult
- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- address what has caused the abuse or neglect
- support good practice and sound professional judgement when dealing with safeguarding concerns
- safeguard adults in a way that supports them in making choices and having control about how they want to live
- promote an approach that concentrates on improving life for the adults concerned
- ensure that information on allegations and incidents of abuse or neglect are collected, monitored and reviewed in order to inform future practice
- complement other related policies, procedures and guidance.

1.2 Working together to protect adults at risk of abuse and neglect

This document describes how the local authority and partner agencies will work together in order to protect adults at risk of or experiencing abuse or neglect. It explains:

- the common values and principles underpinning safeguarding adults at risk of abuse or neglect
- the various types of abuse and neglect and how to recognise signs and symptom of abuse or neglect
- what to do if you suspect abuse or neglect
- how the local authority and partner agencies will respond to concerns of alleged abuse or neglect
- the roles and responsibilities of those involved in safeguarding adults
- criminal offences and adult safeguarding
- safeguarding adults reviews (SARs)
- what the law says about protecting adults at risk of abuse and neglect.

1.3 When to use this policy and procedure

These procedures **MUST** be used where there is a concern, allegation or disclosure of abuse or neglect in relation to any adult at risk who is a resident of the City of Liverpool. They apply to adults who have needs for care and support and because of those needs are unable to protect themselves from abuse and neglect.

1.4 Prisoners and persons in approved premises

The Care Act section 42 duty of enquiry does not apply to adults who are prisoners or who live in approved premises. In these circumstances, prison governors and National Offender Management Service (NOMS) respectively have responsibility.

1.5 Inter-authority safeguarding adults

Safeguarding procedures from the area where the abuse took place must be used, irrespective of who the placing authority is or with which GP the person is registered.

ADASS Protocol for inter-authority investigation of adults at risk of abuse available at:
http://www.adass.org.uk/images/stories/Safeguarding%20Adults/ADSS%20Cross%20Boundary%20Protocol%20-%20Jan%2005.pdf

2. Commitment and principles underpinning safeguarding

The safeguarding inter-agency policy and procedures are committed to ensuring the government's wellbeing principle is embedded and applied to adults safeguarding arrangements in Liverpool.

2.1 Wellbeing principle

The Care Act 2014 introduces a duty to promote wellbeing when carrying out any care and support functions in respect of a person. The wellbeing principle applies in all cases where carrying out any care and support function, or making a decision or safeguarding. It applies equally to adults with care and support needs and their carers.

"Wellbeing" is a broad concept, and it is described as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society.

2.2 Government policy

The government believes that safeguarding is everybody's business, with communities playing a part in preventing, identifying and reporting neglect and abuse and measures need to be in place locally to protect adults with care and support needs.

The state's role in safeguarding is to provide the vision and direction and ensure that the legal framework, including powers and duties, is clear and proportionate whilst maximising local flexibility.

Local multi-agency partnerships should support and encourage communities to find local solutions. These solutions will be different in different places, reflecting, for example, local population, environment, and communities.

Adult safeguarding requires working collaboratively to improve outcomes, rather than duplicating or superseding existing responsibilities for providing safe and effective care. The critical factor is providing care and support, which leads to a positive experience for individuals.

A provider's core responsibility, across health and social care, is to provide safe, effective and high-quality care. Safeguarding concerns will require a variety of responses including a provider or other agency enquiry, a disciplinary process, a clinical governance response from within or by external bodies, the involvement of police, regulators, staff training or other activities.

2.3 The government's six key principles that underpin all adult safeguarding work

- **Empowerment** – People being supported and encouraged to make their own decisions and informed consent ***"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."***
- **Prevention** - It is better to take action before harm occurs ***"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."***
- **Proportionality** – The least intrusive response appropriate to the risk presented ***"I am sure that professionals will work in my interest, as I see them and they will only get involved as much as needed."***
- **Protection** - Support and representation for those in greatest need. ***"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."***
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. ***"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best results for me."***
- **Accountability** - Accountability and transparency in delivering safeguarding. ***"I understand the role of everyone involved in my life and so do they."***

3. Making Safeguarding Personal (MSP)

Making Safeguarding Personal (MSP) is the approach now taken to all safeguarding work. It is a shift in culture and practice in response to what is now known about what makes safeguarding more or less effective from the perspective of the adult being safeguarded. The key principle of MSP is to support and empower each adult to make choices and have control about how they want to live their own life.

MSP means that safeguarding adults should be person-centred and outcome focused. It is about having conversations with people about how responses to safeguarding situations can be made in a way that enhances their involvement, choice and control as well as improving their quality of life, wellbeing and safety. It is about seeing people as experts in their own lives, and working alongside them to identify the outcomes they want.

MSP focuses on achieving meaningful improvements to people's lives to prevent abuse and neglect occurring in the future, including ways for them to protect themselves. People are individuals with a variety of different preferences, histories, circumstances and life-styles, so safeguarding arrangements should not prescribe a process that must be followed whenever a concern is raised, but instead take a more personalised approach.

People cannot make decisions about their lives unless they know what the options are, what the implications of those options may be and have had the chance to really consider them. When safeguarding concerns are raised about people in Liverpool who have care and support needs, who are at risk of or experiencing abuse or neglect and are unable to protect themselves professionals will work with them or their representative or advocate (if they have substantial difficulty understanding the enquiry) to develop a real understanding of what they wish to achieve.

Professionals leading safeguarding enquiries should take time to consider what information needs to be made available to assist people at the right times, in what format, and allow time for information to be understood. Professionals will work with adults agreeing, negotiating and recording their desired outcomes, and how best those outcomes might be realised. At the end of the enquiry, the extent to which these desired outcomes have been realised will be assessed.

Making safeguarding personal requires a conversation with the adult or their representative or advocate at the earliest opportunity.

The three main questions to ask at the outset are:

- what difference is wanted or desired
- how will you work with someone to enable that to happen
- how will you know that a difference has been made.

Each adult needs to be supported to explore the choices and responses that they may want during an enquiry (which may change from their initial wishes as the enquiry proceeds).

3.1 What are outcomes?

The Local Government *Association's Making Safeguarding Personal: Guide 2014* (Fourth edition) reports that by and large people express a desire for realistic outcomes and describes some of the outcomes that people wish to achieve:

"What difference is wanted or desired?"

- people are safe from continuing harm and/or abuse
- people feel that they have recovered from the abuse or neglect
- people are empowered and able to manage their situations
- people are aware of services and options to meet their needs.
- people have their stated objectives and desired results met.
- people have access to independent advice and support
- the person believes that their views, worries and wishes are taken seriously
- the person reports that they haven't had to compromise their safety and wellbeing at the cost of having relationships with other people
- the person develops stronger networks that are also protective
- the person knows how to take precautions against harm and how to keep safe
- the person knows who to contact to find out information
- the person feels in control and not driven or controlled by the adult safeguarding process
- the person can get help from someone who is independent.

This is not an exhaustive list. Wherever possible it is better to capture an individual's outcomes in their own words: "I want to feel safe in my own home again"

http://www.local.gov.uk

Professionals must maintain contact with the adult (representative/advocate) as the enquiry proceeds. At the end of the enquiry, professionals must review with the adult if their desired outcomes have been achieved. This must be recorded on the safeguarding outcome enquiry report.

4. What are abuse and neglect?

This section provides commonly and nationally used definitions and should be used to guide all adult safeguarding work across all partner agencies and individuals. This is not intended to be an exhaustive list but a guide as to the sort of issues or behaviour which could give rise to a safeguarding concern.

4.1 Definitions

Abuse or neglect is any behaviour towards a person that deliberately or unknowingly causes him or her harm, endangers their life or violates their rights. This may be the result of deliberate intent, negligence or ignorance. Exploitation can be a common theme in the experience of abuse or neglect. Whilst it is acknowledged that abuse or neglect can take different forms, the Care Act guidance identifies the following types of abuse or neglect:

- physical abuse
- domestic abuse
- sexual abuse
- psychological abuse
- financial or material abuse
- modern slavery
- discriminatory abuse
- organisational abuse
- neglect and acts of omission
- self-neglect.

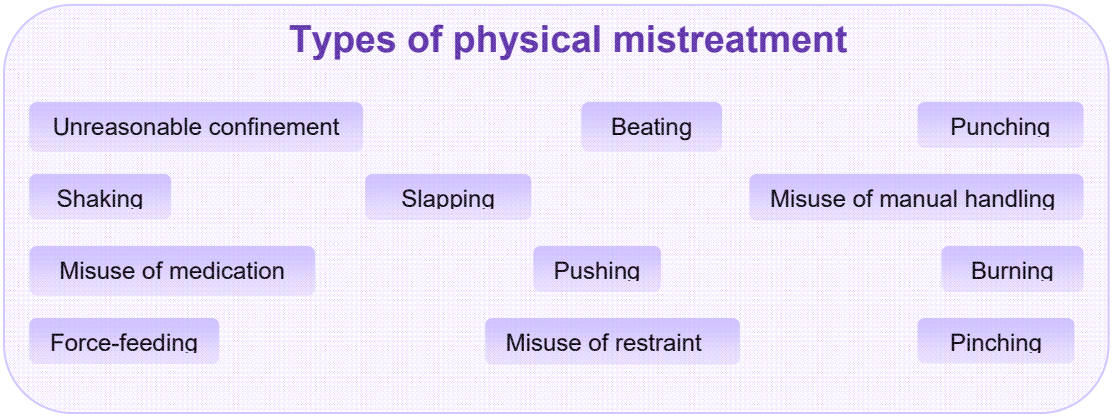
These types of abuse or neglect are explored in more detail in the following sections.

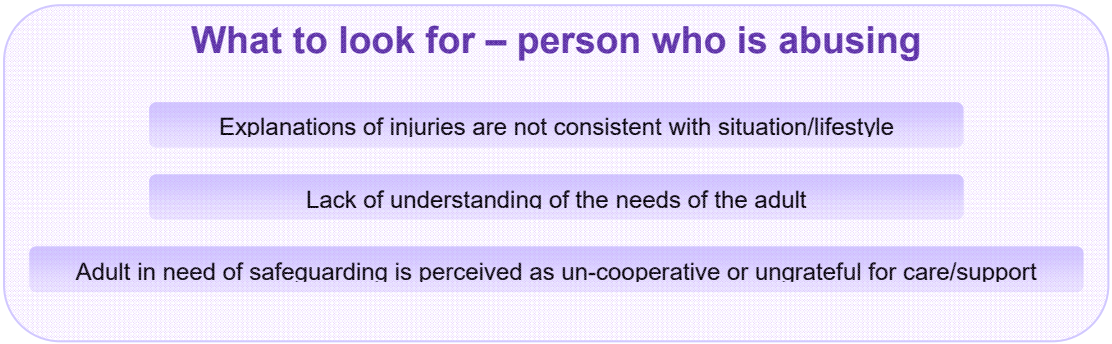
4.2 Indicators of abuse

The following lists are purely indicators. The presence of one or more does not necessarily confirm abuse. The lists are not definitive.

4.3 Definition of physical abuse and what to look for

Physical Abuse is the physical mistreatment of one person by another which may or may not result in physical injury





4.4 Definition of sexual abuse and what to look for

Sexual Abuse is any form of sexual activity that the adult does not want and to which they have not consented, or to which they cannot give informed consent or were pressured into consenting.

Types of sexual abuse

- Serial abuse over a long period of time after identifying a person perceived as vulnerable
- Assault by penetration (of mouth, vagina, anus by any body-part or any object)
- Use of offensive or suggestive language
- Abuser exposing genitals
- Forcing the person to watch/look at pornography
- Full sexual intercourse
- Rewards for sexual acts
- Rape (penetration of mouth, vagina, anus with penis)
- Sexual activity with a mentally disordered person
- Abuser touching victim's body
- Sexual relationships instigated by those in a position of trust

What to look for - signs of being abused

- Recoiling from physical contact
- Genital discharge
- Fear of males or females
- Persistent and inappropriate sexual behaviour especially in the presence of certain persons
- Torn, stained or bloody garments
- Not consenting to or understanding sexual activity
- Sudden use of offensive sexual language
- Bruising / lacerations to upper thighs
- Recurring genital irritation
- Unexplained sexually transmitted diseases
- Disclosure
- Pronounced overly affectionate behaviour
- Pregnancy
- Unusual difficulty walking

What to look for – person who is abusing

- Personal care tasks taking significantly longer to perform than usual
- Use of offensive or suggestive sexual language
- Over enthusiastic in carrying out personal care tasks, working alone with adults
- Openly showing favouritism and/or the giving of gifts for no apparent reason

4.5 Definitions of psychological abuse and what to look for

Psychological abuse may involve the use of intimidation, indifference, hostility, rejection, threats, humiliation, shouting, swearing or the use of discriminatory and/or oppressive language.

Types of psychological abuse

- Gross restriction of freedom
- Person's access to personal hygiene and toilet restricted
- Threat to withdraw care/support
- Withholding of security and affection
- Name-calling
- Humiliation or ridicule not treating with respect
- Denial of the opportunity for privacy
- Threat of institutional care
- Provoking fear of violence
- Shouting and swearing
- Adult's choices, opinions and wishes being neglected/rejected
- Use of bribes or threats

What to look for - signs of being abused

- Stress and / or anxiety in response to certain people
- Displays compulsive behaviour
- Withdrawn, unresponsive and displays overly compliant behaviour
- Disclosure
- Reduction in skills and concentration
- Lack of trust particularly with significant others
- Changes in sleep pattern
- Frightened of specific individuals
- Lack of self esteem

What to look for - person who is abusing

- Withholding affection
- Denial of social and cultural contact
- Discriminatory comments
- Denial of reasonable requests
- Use of abusive language or shouting
- Denying privacy
- Lack of understanding of the needs of the adult
- Ignoring the person
- Use of threats
- Adult in need of safeguarding is perceived as un-cooperative or ungrateful for care/support

4.6 Definition of financial or material abuse and what to look for

Financial or material abuse is the misappropriation or misuse of money / assets, or transactions to which the person could not consent or which were invalidated by intimidation / deception.

Types of financial abuse

- Not allowing the person access to their money
- Not spending allowances on the individual
- Use of personal allowances to pay for care
- Theft of monies
- Denying access to money
- Scams
- Mismanagement of bank accounts
- Misuse of Power of Attorney
- Theft of property
- Withholding pension or building society book
- Misuse of benefits
- Unreasonable restriction of a person's right to control their lives to the best of their ability

What to look for - signs of being abused

- Over protection of money or property
- Money not available
- Forged signatures
- Unexplained withdrawals from accounts
- Account does not balance
- Disclosure
- Lack of money especially after benefit day
- Unable to account for monies being spent
- Accounts balancing but errors found in accounting for activities
- Inability to pay bills
- Losses from accounts disguised for activities
- Insufficient funds in account

What to look for – person who is abusing

- Money earned by carers does not equal that being spent
- Evasive when discussing finances
- Buying goods with own preference as a priority
- Goods bought being frequently worn, used or in the possession of the abuser
- Over keenness to participate in activities involving individual's monies

4.7 Definition of neglect and what to look for

Neglect / Acts of omission is behaviour that results in the persistent or severe failure to meet the physical and / or psychological needs of an individual in their care.

Types of neglect

- Wilful failure to intervene, or consider the implications of non-intervention in behaviour which is dangerous to the individual concerned or to others
- Failure to use agreed risk-taking procedures resulting in the person taking unnecessary risks
- Inadequate care in hospital/residential settings
- Denying access to services or advocacy
- Withholding affection or communication
- Withholding food/drinks/heat/light/clothing
- Withholding of aids, e.g. hearing aids, spectacles, walking aids
- Inadequate furnishings
- Limiting choice
- Not providing access to medical care or giving personal care

What to look for - signs of being abused

- Depression / fear
- Person is isolated
- Continence problems
- Dehydration
- Unkempt look
- Person not allowed visitors or phone
- Person locked in room
- Demanding e.g. food and / or drink
- Access to personal hygiene and toilet is restricted
- Deterioration of health
- Pressure ulcers
- Complaints of pain or discomfort
- Sleep disturbance
- Disclosure by person using service
- Low self-esteem
- Unexplained accidents
- Exposed to inappropriate stimuli
- Disclosure

What to look for – person who is abusing

- Seemingly uncaring attitude and cold detachment from individual
- Frequent failure to report individual's progress to others
- Denying individual's requests
- General lack of consideration toward the needs of the individual
- Individual perceived as uncooperative or ungrateful for care / support given
- Denying others, including health and social care professionals, access to the individual

4.8 Definition of discriminatory abuse and what to look for

Discriminatory abuse is based on a person's race, culture, belief, gender, age, disability, sexual orientation and may be the motivating factor in other forms of abuse.

Types of discriminatory abuse

Any form of discrimination both direct and indirect based on the person's race, language, religion, faith and belief and his or her cultural norms and values, gender, sexuality,disability, class, age, HIV status

Can be in the form of personal or organisational discrimination

Organisational discrimination being where systems and structures directly or indirectly discriminate against potential or actual users of the service

Personal discrimination being the prejudice of the individual e.g. treatment/perception of person because of a person's appearance etc

Hate crime

What to look for - signs of being abused

Withdrawal or rejection of culturally inappropriate services e.g. food, mixed gender groups or activities

Sometimes the individual may agree with the abuser just to have an easier life

Disclosure

Low self-esteem

What to look for – person who is abusing

May react when challenged by saying 'I treat everyone the same' or 'they are getting the same treatment as everyone else'

Enforcing rules and procedures which undermine the individual's wellbeing

Sees individual as not conforming to the system

Use of inappropriate 'nicknames'

Use of derogatory language / terminology

Sees individual as uncooperative

Lack of understanding and / or respect for person's emotional needs

Denial of social and cultural contact

Stereotyped views of the individual

4.9 Definition of organisational abuse and what to look for

Organisational abuse is repeated incidents of poor professional practice or neglect or inflexible services based on the needs of providers rather than the person receiving services

Types of organisational abuse

- People using the service required to 'fit in' excessively to the routine of the service
- System that encourages/allows or condones poor practice
- Deprived environment
- Lack of procedure / guidelines for staff
- One commode used for a number of people
- Repeated/unaddressed incidents of poor practice
- Little or no evidence of training
- Manager/person in charge implicated in poor practice
- Lack of staff support/guidance
- Lack of homely environment, stark living areas
- Lack of privacy for personal care

What to look for - signs of being abused

- Lack of personal clothing / possessions
- No support plan
- Lack of stimulation
- Left on commode for long periods
- No or inadequate risk assessment/management plans
- Unexplained bruising / burns
- Repeated infections
- Repeated falls
- Recoiling from specific individuals
- Unauthorised deprivation of liberty
- Pressure ulcers
- Limited or no access to primary / secondary healthcare

What to look for – person who is abusing

- Lack of understanding of people's disability/conditions
- Misuse of medication
- Use of illegal control and restraint
- Staff seeing people using the service as a nuisance
- Inappropriate use of power/control
- Undue/inappropriate physical intervention
- Rough handling
- Coercion
- Misuse of nursing/medical procedures
- Staff seeing that their wishes/needs take priority over those of the people they support

4.10 Definition of self-neglect and what to look for

Self-neglect covers a wide range of behaviour; neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Self-neglect it is also defined as the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and wellbeing of the individual and sometimes to their community.

Indicators of self-neglect may be:

- living in very unclean, sometimes verminous, circumstances
- poor self-care leading to a decline in personal hygiene
- refusing necessary help from health and/or social care in relation to personal hygiene and care
- poor diet or nutrition
- having poor personal hygiene, poor health/sores or long toe nails
- poorly maintained clothing
- isolation
- failure to take medication
- hoarding large numbers of pets
- neglecting household maintenance and therefore creating hazards or fire risks
- portraying eccentric behaviour/lifestyles.

NOTE: Poor environments and personal hygiene may be a matter of personal or lifestyle choice or other issues such as insufficient income.

4.11 Definition modern slavery and what to look for

Modern slavery encompasses, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment**.** Victims can often face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation

Signs of slavery in the UK and elsewhere are often hidden, making it even harder to recognise victims around us. Whilst not exhaustive, here is a list of **some common signs** which you can be aware of:

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

Source: **https://modernslavery.co.uk/**

4.12 The definition of domestic abuse and what to look for

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality.

The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional.

4.12.1 Controlling behaviour

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

4.12.2 Coercive behaviour

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

It has been widely understood for some time that coercive control is a core part of domestic violence. As such the extension does not represent a fundamental change in the definition. However it does highlight the importance of recognising coercive control as a complex pattern of overlapping and repeated abuse perpetrated within a context of power and control.

Without the inclusion of coercive control in the definition of domestic violence and abuse, there may be occasions where domestic violence and abuse could be regarded as an isolated incident. As a result, it may be unclear to victims what counts as domestic violence and abuse – for example, it may be thought to include physical violence only. We know that the first incident reported to the police or other agencies is rarely the first incident to occur; often people have been subject to violence and abuse on multiple occasions before they seek help.

Domestic violence (abuse) is mainly perpetrated by men towards women. This is not to deny the existence of violence towards men or that women abuse. We acknowledge that violence occurs between same sex partners.

Domestic violence (abuse) occurs in all communities. Certain groups may face additional barriers and discrimination when trying to access services as a result of such violence

This is not a legal definition.

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

4.12.3 Forced marriage

- Forced marriage is one in which one or both spouses do not consent to the marriage and some element of duress is involved, including the use of physical and emotional pressure.

- Forced Marriage is not sanctioned within any culture or religion. See link below Liverpool Forced Marriage Protocol

http://www.liverpoolscb.org/files/forced_marriage_protocol.pdf

- The government regards Forced Marriage as an abuse of human rights and a form of domestic abuse and, where it affects children and young people, child abuse.

4.12.4 So called 'Honour' Based Violence (HBV)

HBV is where the person is being punished by their family or their community. They are being punished because of a belief, actual or alleged, that a person has not been properly controlled enough to conformity and thus this is to the 'shame' or 'dishonour' of the family. 'HBV' is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community members.(ACPO 2007.)

All practitioners working with victims of forced marriage and HBV need to be aware of the **'one chance' rule.** That is, they may only have **one chance** to speak to a potential victim and may only have **one chance** to save a life.

4.12.5 Range of abuse

It is important to understand that domestic violence (abuse) takes a variety of forms. As well as physical violence, other forms of abuse for example, psychological abuse and/or emotional abuse have an equally negative impact upon the person's health and wellbeing.

4.12.6 Legislation

There is no specific offence of domestic violence (abuse). Cases are progressed using criminal legislation (assault, criminal damage, sexual assault, rape and murder to name a few). The Police will investigate incidents of domestic violence (abuse) and based on the evidence collected the Crown Prosecution Service will then make a decision in relation to charging of the case.

There are also a number of civil remedies available to victims of domestic violence (abuse). Specialist domestic violence support services and solicitors will be able to explain options to a victim in order for them to make an informed decision on their next steps.

In 2004, the Domestic Violence Crime and Victims Act (2004) saw the introduction of a number of measures to provide additional protection for victims of domestic violence (abuse). The breach of a non molestation order (obtained in the civil courts) was made a criminal offence. This means that if perpetrators choose to breach the civil order they can be arrested and charged for this.

The Act also provides that members of a household who have frequent contact with a child or vulnerable adult will be found guilty if they caused the death of that child or vulnerable adult, or three conditions are met:

- they are aware or ought to have been aware that the victim was at significant risk of physical harm from a member of the household
- they failed to take reasonable steps to prevent that person coming to harm and
- the victim subsequently died from the unlawful act of a member of the household in the circumstances that the defendant foresaw or ought to have foreseen.

5. Who abuses, where and when does abuse occur?

Perpetrators of abuse and neglect

It must be acknowledged that perpetrators of abuse can be any of the following:

- informal carers, including neighbours, friends and relatives
- partners, ex-partners and other family members
- people in a position of trust
- people paid to provide care or services
- other users of services
- strangers
- organisations by the way they conduct their day-to-day practice can cause harm.

5.1 Perpetrators of abuse in positions of trust

There is particular concern when someone perpetrates abuse when they are in a position of trust, power or authority, and where they may have access to a number of potential victims.

Perpetrators may be in need of safeguarding themselves. Organisations will have a responsibility to these individuals as well as to the victim. As an increasing number of people receive support through Direct Payment and Self Directed Support there is potential risk from unregulated care providers / personal assistants.

5.2 Informal care

In the context of informal care abuse can be an isolated incident, repeated acts or pervasive ill treatment resulting in harm. Abuse may be intentional or unintentional.

5.3 Range of abuse

Abuse can range from isolated incidents of poor practice at one end of the spectrum, through to pervasive ill treatment and/or gross misconduct at the other. Abuse may be intentional or unintentional.

5.4 Multiple incidents

Incidents of abuse may be multiple:

- to one person in a continuing relationship or service context

- to more than one person at a time
- by more than one perpetrator at a time.

Repeated incidents of poor care may be an indication of more serious problems, for example organisational abuse. Organisational abuse features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the system.

5.5 Risk factors

There are certain factors and situations that may place people at particular risk of being abused. The presence of one or more of these factors does not automatically imply abuse will result, but may increase the likelihood:

- need for intimate personal care
- certain personal care needs may present more opportunity for abuse
- role reversal, for example, the adult child taking over the parental role
- a person needing care which is beyond the ability of the carer to provide
- living in the same household as a known abuser
- long-term abuse in the context of an ongoing family relationship such as domestic violence between partners or between generations
- where an adult is dependent on others, or others are dependent on them
- inappropriate or dangerous physical or emotional environment, for example, lack of personal space
- where there is a change in the lifestyle of a household member, for example, unemployment, employment, illness
- a member of the household experiencing emotional or social isolation
- the existence of financial problems
- difference in communication or a breakdown in communication
- a carer has been forced to substantially change their lifestyle
- isolated families may become victims and targets of bullying, harassment, hate crime and anti-social behavior.

6. Related issues

This section covers a number of issues which may need to be considered when working to safeguard adults with needs for care and support

6.1 Hate Crimes/ Incident which includes:

- any incident which may or may not constitute a criminal offence, which is perceived by the victim or other person as being motivated by prejudice or hate
- the Hate Crime or incident can be any incident which is usually targeted at someone or a family due to their:

    - race
    - disability
    - gender
    - age
    - religion
    - sexual orientation
    - transgender.

Information relating to hate crimes is available from the Home Office website:

Available at**:**
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266358/hate-crime-2013.pdf

6.2 Mate crimes

There is no statutory definition of mate crime in UK law. The term is generally understood to refer to the befriending of people, who are perceived by perpetrators to be vulnerable, for the purposes of taking advantage of, exploiting and/or abusing them. This can strongly be associated, but not exclusively associated, with people with a learning disability, learning difficulties or mental health conditions

Different types of mate crime can include:

- theft or financial abuse, the abuser might demand or ask to be lent money and then not pay it back. The perpetrator might misuse the property of the adult
- physical assault or abuse. The abuser might hurt or injure the adult
- harassment or emotional abuse. The abuser might manipulate mislead or make the person feel worthless.

6.3 Multi Agency Risk Assessment Conference (MARAC)

A MARAC is a local information sharing meeting where the focus is domestic abuse cases of the highest risk. The meeting involves representatives of the local police, probation, health, local children services, adult services, community safety, housing practitioners, substance misuse services, Independent Domestic Violence Advisers (IDVAs) and other specialists from the statutory and voluntary sector.

The four aims of a MARAC are:

- to safeguard any adults who are at high risk of domestic abuse
- to make links with other protection arrangements in relation to children, people causing harm and adults with care and support needs
- to safeguard staff
- to work towards addressing and managing the behaviour of the person causing harm.

Any agency receiving disclosure of domestic abuse is able to refer the case to MARAC, once they have completed the Merseyside Risk Indicator Toolkit (MERIT)

Where the person experiencing domestic abuse is an adult covered by the safeguarding criteria, a concern should always be raised under the adult safeguarding procedures. The MERIT will assist practitioners assess the level of risk. (See appendix I.)

6.4 Domestic Homicide Reviews

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004) which came into effect on 13 April 2011.

Under guidance issued by the Home Office, any incident of domestic violence or abuse which results in the death of the victim requires a Domestic Homicide Review (DHR). This is to be carried out by the local Community Safety Partnership. In Liverpool the safer and stronger communities team co-ordinate the review process.

The purpose of the multi-agency review is to ensure that agencies are responding appropriately to victims of domestic violence and to apply any lessons learned through an action plan or recommendations. They are not inquiries into who is culpable; this is for the court or coroner to decide.

Please click here to view Home Office 'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'

https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

6.5 Multi-Agency Public Protection Arrangements (MAPPA)

MAPPA are a set of arrangements to manage the risk posed by the most sexual and violent offenders (MAPPA-eligible offenders) under the provisions of section 325 to 327B of the Criminal Justice Act 2003. They bring together the police, probation and prison service into what is known as the MAPPA responsible authority.

A number of other agencies are under a Duty to Cooperation (DTC) with the responsible authority. These include social services, health trusts, youth offending teams, job centre plus and local housing and education authorities.

MAPPA-eligible offenders are identified and information about them is shared by agencies in order to inform the risk assessments and risk management plans of those managing or supervising them.

In the majority of cases, that is as far as MAPPA extends, but in some cases, it is determined that active multi-agency management is required. In such cases there will be regular MAPPA meetings attended by relevant agency practitioners

There are 3 categories of MAPPA-eligible offender:

- category 1 – registered sexual offenders
- category 2 – (in the main) violent offenders sentenced to imprisonment for 12 months or more
- category 3 – offenders who do not qualify under categories 1-2 but who pose a risk of serious harm.

Cases can be referred to MAPPA via the link below:

nwnps.merseyside.mappa@probation.gsi.gov.uk

6.6 Channel

Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. The programme uses a multi-agency approach to protect vulnerable people by:

- identifying individuals at risk
- assessing the nature and extent of that risk and
- developing the most appropriate support plan for the individuals concerned.

Channel may be appropriate for anyone who is vulnerable to being drawn into any form of terrorism. Channel is about ensuring that vulnerable children and adults of any faith, ethnicity or background receive support before their vulnerabilities are exploited by those that would want them to embrace

terrorism, and before they become involved in criminal terrorist related activity.

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

There is no obvious profile of a person likely to become involved in extremism or a single indicator of when a person might move to adopt violence in support of extremist ideas. The process of radicalisation is different for every individual and can take place over an extended period or within a very short time frame. Research has however identified that during this process opportunities arise when recognition, intervention and then support can be provided to divert the individual away from extremist activity.

To reduce the risk from terrorism we need not only to stop terrorist attacks but also to prevent people becoming terrorists. This is one objective of **CONTEST**, the Government's strategy for countering all forms of violent extremism.

Any concerns that an adult with needs for care and support that may be at risk of being radicalised must be reported as a safeguarding concern to Careline on: 0151 233 3800.

Professionals wishing to make a referral to the multi-agency channel panel should complete a referral (see appendix J) and send to: carelineadultservices@liverpool.gcsx.gov.uk

Further information regarding Channel can be found by accessing the link below:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/425189/Channel_Duty_Guidance_April_2015.pdf

6.7 Mental Capacity Act (MCA) - Deprivation of Liberty Safeguards (DOLS)

In April 2009 a new provision under the Mental Capacity Act 2005 came into force. This provision is designed to safeguard those who do not have the capacity to consent to the arrangements made for their care or treatment.

This provision applies to those who are accommodated under care and treatment regimes that may have the effect of depriving them of their liberty. The safeguards have been created to ensure that any decision to deprive someone of their liberty is made following defined processes. Depriving someone of their liberty is a safeguarding issue in itself if not authorised in accordance with a procedure prescribed by law.

The MCA DOLS is designed to protect people who lack capacity and require to be cared for in a restrictive way that cannot be avoided. The decision as to whether or not a deprivation of liberty arises will depend upon all the circumstances of the case.

In March 2014 The Supreme Court gave guidance on what amounts to a deprivation of liberty. The judgement is a re-affirmation of the law. The terms “continuous supervision and control” and “not free to leave” appeared in paragraph 91 in the Bournewood judgement from the European Court in 2004 (HL v UK 45508/99 (2004) ECHR 471).

A person may be deprived of their liberty if:

- they do not have the capacity to consent to their care and treatment and
- they are under continuous supervision and control and
- the person is not free to leave.

It is the care home or hospital (under this legislation known as Managing Authority) who are responsible for assessing any restraint or restrictions in place to ensure that they always implement the least restrictive option. Where the constraints of an individual’s personal freedom go beyond ‘restraint’ or ‘restriction’, to the extent they constitute a deprivation of their liberty, the managing authority must apply for an authorisation otherwise the deprivation becomes unlawful.

In Liverpool we have a single point of entry for applications from care homes and hospitals. If the deprivation is already occurring, the managing authority can issue an urgent authorisation that can last up to seven days. At the same time they must apply for a standard authorisation

Standard forms for application and guidance is available from the Department of Health website:

http://www.adass.org.uk/mental-health-Drugs-and-Alcohol/public-content/New-DoLS-Forms/

The completed document is then forwarded to:

deprivationoflibertysafeguards@liverpool.gov.uk

Where it will be processed by the deprivation of liberty team.

The **Supervisory Body** (local authority) is responsible for commissioning two suitably qualified assessors to undertake six assessments.

Mental health assessor carries out:

- eligibility
- mental health.

Best interest assessor carries out:

- age
- no refusals
- capacity
- best interests.

If all the assessments conclude that the relevant person meets the requirement for authorisation then the supervisory body will authorise the deprivation of liberty for a period of time no longer than that specified by the best interest assessor. It cannot be longer than 12 months.

Failure to follow the Mental Capacity Act, deprivation of liberty safeguards could result in an unlawful deprivation of liberty.

The inspection bodies will look at the deprivation of liberty procedures in place within the managing authorities and supervisory bodies.

6.7.1 Chief Coroners Guidance No. 16

Managing authorities (care homes and hospitals) have a duty to notify the coroner of any death occurring whilst the deceased was subject to detention under the deprivation of liberty safeguards. This must take place immediately.

The coroner must then hold an inquest which may consider whether the death was related to the actual deprivation of liberty. See appendix R what happens if someone dies whilst subject to a Deprivation of Liberty Safeguards (DoLS) Authorisation.

In addition to contacting the coroner, care homes must notify the police.

Failure to notify the coroner has serious consequences and responsibility is likely to be shared between the supervisory body and the managing authority.

https://www.judiciary.gov.uk/wp-content/uploads/2013/10/guidance-no16-dols.pdf

For more details of the DOLS process or information about how to make an application please contact:

deprivationoflibertysafeguards@liverpool.gov.uk

Tel: 0151 233 0805

7. Capacity and consent

In every situation it is assumed that an adult has the mental capacity to make informed choices about their own safety and how they live their lives. Issues about mental capacity and the ability to give informed consent are central to decisions and actions in safeguarding adults. All interventions need to take account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability:

- to understand the implications of their situation
- to take action themselves to prevent abuse
- to participate to the fullest extent possible in decision making about interventions.

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions are life changing events or everyday matters. All decisions taken into the safeguarding adults process must comply with the Act.

A person lacks capacity in relation to a matter if at the material time he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Further, a person is unable to make a decision for him/herself if he/she is unable:

- to understand the information relevant to make the decision
- to retain the information
- to use or weigh that information as part of the process of making the decision, or
- to communicate his / her decision (whether by talking, using sign language or any other means) (Mental Capacity Act 2005).

During the enquiry, it is essential that you are certain that the person fully understands the nature of the concerns and the choices facing them. You must ensure that you explain the decision in a way that an adult could understand. Avoid the use of jargon and consider easy read documents when appropriate.

It should never be assumed that because the person lacks capacity in respect to one aspect of their lives, this equates directly to another situation. A single assessment approach should be made in relation to the presenting issue.

7.1 An assessment in respect of capacity should:

- relate to the timing and nature of a particular incident

- consider whether the person is able to understand or retain the information relevant to the decision to be made
- consider whether the person is able to make a decision based on that information
- be fully recorded in the case file.

7.2 Circumstances where the person is considered to lack capacity might include those:

- where the person does not know that they have a decision to make
- where the person does not understand the choices available or the consequences of those choices
- where the person cannot communicate their decision. Every effort must be made to assist the person's understanding of the situation and the communication of their wishes.

If it is established that a person does not have capacity to make the specific decision at the specific time required, then a best interests decision must be determined on their behalf. When determining best interests you must comply with the Mental Capacity Act, bearing in mind the nature of the decision.

You may decide that you need to call a meeting. The purpose of this meeting is to ensure that all relevant factors are taken into account, including the person's wishes and feelings and that the relevant people have been consulted. Any decision made on behalf of the person must be in their best interest and be least restrictive of the person's rights.

All assessments of capacity and best interest decisions made on behalf of another person must be recorded on the relevant assessment of capacity and best interest decision form. If a best interest decision is appealed then legal advice must be sought.

7.3 Intimidation and coercion

There may be situations where a person seems able to make their own decisions in terms of their knowledge and understanding. However, they may be subject to undue pressure or too afraid to disagree with a particular course of action. If you feel this is the case the person should be offered distance from the situation in order to facilitate decision-making.

7.4 When a person has capacity

If it is decided that a person does have capacity and has taken an informed choice to live in a situation that puts them at risk, you should consult with:

- the person themselves
- their community support
- any other relevant organisations, service or individual. This will ensure all possible choices available to the person are offered to them.

The person may still choose to stay in the situation and live with that risk.

7.5 Meaningful consent

In order for consent to be meaningful and legal, there are two criteria that need to be satisfied:

- the person must have the capacity to consent
- the consent must be their own choice and must be given freely and not through coercion, intimidation or pressure from family or professionals.

7.6 When an adult does not want information shared and there is a professional responsibility to do so

Where an adult with capacity to make an informed decision about their own safety does not want any action taken, this does not override a professional's responsibility to raise a safeguarding concern and to share key information with relevant professionals e.g. where others are at risk, a criminal offence has been committed etc.

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

In these situations the adult must always be:

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

7.7 Where an offence may have been committed

If it is suspected that an offence may have been committed, there should always be a conversation with the adult regarding whether they wish the police to be involved.

If the adult does not want the police to be involved, this does not override a professional's responsibility to share information regarding a potential, or actual, offence with them.

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

7.8 Adults who lack capacity to make relevant decisions

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

7.9 Independent Mental Capacity Advocate (IMCA)

The Mental Capacity Act 2005 makes provision for an Independent Mental Capacity Advocate (IMCA) to assist a person who lacks capacity to make decisions.
An IMCA **must** be instructed, and then consulted for people lacking capacity who have no-one else to support them, other than paid staff in relation to decisions proposing:

- serious medical treatment
- long term change of accommodation or
- in hospital for 28 days or longer.

7.10 Independent advocate

The Care Act requires that an independent advocate must be instructed to represent an adult who is the subject to a safeguarding enquiry or safeguarding adults reviews where the adult has 'substantial difficulty' in being involved in the safeguarding process and where there is no other suitable person to represent and support them.

Please click on the link below to make a referral to advocacy experience for an independent advocate:

http://www.advocacyexperience.com

8. Information sharing to prevent and safeguard adults from abuse or neglect

Information sharing is key to the Government's goal of delivering better, more efficient public services that are co-ordinated around the needs of the individual. It is essential to enable early intervention and preventative work, for safeguarding and promoting wellbeing and for wider public protection. Information sharing is a vital element in improving outcomes for all.

The Government understands that it is most important that people remain confident that their personal information is kept safe and secure and that practitioners maintain the privacy of the individual, whilst sharing information to deliver better services. It is therefore important that practitioners can share information appropriately, as part of their day-to-day practice and do so confidently.[1]

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

Personal information held by professionals and agencies is subject to a legal duty of confidentiality and should normally only be disclosed to third parties, including other organisations, with the consent of the subject of the information. However there may be times when it will be necessary to disclose information without the subject's consent.

8.2 Summarising the principles set out in the Caldicott Committee's Report:

- information will only be shared on a need to know basis when it is in the best interest of the adult
- confidentiality must never be confused with secrecy
- informed consent should be obtained, but if this is not possible and others are at risk, it may be necessary to override this requirement
- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in situations when other people may be at risk.

The information exchanged under this guidance will only be used for safeguarding adults' purposes and where it meets these conditions:

- a criminal offence has taken place
- it may prevent a crime
- the alleged victim is at risk of harm

[1] Information Sharing: Guidance for Practitioners and Managers, p5 www.education.gov.uk

- staff , other adults, or the general public may be at risk of harm
- for the early intervention and identification of abuse
- for enquiries under safeguarding procedures.

8.3 Before you share information you need to ask yourself the following questions:

- do I have the permission of the person to disclose personal information?

If not:

- do I have the legal power to disclose this information?
- is there a duty to protect the wider public interest, are other people at risk?
- am I proposing to share information with due regard to both common and statute law?
- do I have the correct level of seniority to disclose this information?
- if there is an allegation relating to a professional, outside of their work role Careline must be informed, see managing allegations against professionals policy

  http://lccintranet.liverpool.local/organisation/directorates/adult-services-and-health/policies-and-guidance/

8.4 Legitimate purposes include:

- preventing serious harm to an adult; including through prevention, detention and prosecution of a serious crime
- providing urgent medical treatment to an adult
- implementing the Care Act 2014, which aims to protect adults with care and support needs from abuse and neglect.

8.5 Public interest includes:

- when there is reasonable cause to believe that an adult is suffering, or is at risk of suffering serious harm
- to prevent the adult from harming someone else
- to promote the wellbeing of the adult
- detecting crime
- apprehending offenders
- maintaining public safety.

Breaching the Data Protection Act is extremely serious and could result in both the individual practitioner and the local authority being held accountable. The sharing of personal information must always be discussed with a manager, legal services or data protection officers within the authority.

8.6 Legal framework

8.6.1 Data Protection Act 1998

- requires that personal information is obtained and processed fairly and lawfully
- only disclosed in appropriate circumstances
- is accurate, relevant and
- is held no longer than necessary; and is kept securely.

The Act allows for disclosure without the consent of the subject in certain circumstances, including:

- the prevention or detection of crime
- the apprehension or prosecution of offenders
- where failure to disclose would be likely to prejudice those objectives in a particular case.

8.6.2 The Human Rights Act 1998
Article 8.1 of the Act provides that:

'Everyone has the right to respect for his private and family life, his home and correspondence'.

This is a qualified right as Article 8.2 states:

'There shall be no interference by a public authority with the exercise of this right except in accordance with the law and as necessary in a democratic society in the interests of national security, public safety, or the economic wellbeing of the country, for the prevention of disorder or crime for the protection of health or morals or for the protection of the rights and freedoms of others'

8.6.3 Public Interest Disclosure Act 1998

The Act introduces the concept of 'protected disclosure'. This is a disclosure where the employee has the reasonable belief that one of the following is occurring:

- a criminal offence has or is likely to be committed
- a person has failed, is failing or is likely to fail to comply with any legal obligation
- a miscarriage of justice has occurred, is occurring or is likely to occur

- the health and safety of any individual has been, is being, or is likely to be endangered
- the environment has been, is being, or is likely to be damaged
- information tending to show any matter falling within the any one of the above has been, is being, or likely to be deliberately concealed.

8.6.4 The Care Act 2014 Supply of Information

Under Section 45 of the Care Act, if a Safeguarding Adults Board (SAB) requests a person to supply information to it or to some other person specified in the request, the person who receives the request must provide the information provided to the SAB if:

- the request is made in order to enable or assist the SAB do its job
- the request is made of a person who is likely to have relevant information, and then either:
    - the information requested relates to the person whom the request is made and their functions or activities or
    - the information requested has already been supplied to another subject to an SAB request for information.

Information may be used by the SAB, or other person to whom it is supplied under subsection (1), only for the purpose of enabling or assisting the SAB to exercise its functions.

8.6.5 Common Law Duty of Confidentiality

The duty of confidentiality requires that unless there is a statutory requirement to use information that has been provided in confidence, it should only be used for purposes that the subject has been informed about and has consented to. This duty is not absolute, but should only be overridden if the holder of the information can justify disclosure as being in the public interest, that is, to protect others from harm.

8.7 Sharing information with families

It is important to manage the expectations of what a family member/carer assumes will be made available during, and at the conclusion of, any safeguarding enquiry.

If an adult lacks capacity to consent to sharing information, then any information disclosed must comply with the Mental Capacity Act and Data Protection Act.

Family members requesting information regarding safeguarding incidents should be advised that any safeguarding incident will be dealt with through the safeguarding adults policy and procedures.

8.8 Seven golden rules for information sharing

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.

4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.

5. Consider safety and wellbeing: Base your information sharing decisions on considerations of the safety and wellbeing of the person and others who may be affected by their actions.

6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

9. Thresholds for initiating safeguarding concerns

This section aims to ensure that concerns involving adults who may be at risk of abuse or neglect is dealt with in the most appropriate way. This guidance is intended to assist best practice in decision-making when trying to identify when a concern being raised is about the quality of a service or a safeguarding concern.

9.1 What is a 'safeguarding concern'?

A 'safeguarding concern' is when any person has reasonable cause to think that an adult with needs for care and support, is experiencing, or is at risk of, abuse or neglect and is unable to protect themselves because of those needs.

9.2 Adults with care and support needs

This section describes adults who may need extra support to manage their lives and be independent. This may include:

- people with a learning disability or physical disability
- people with mental health needs
- people with sensory needs
- people with cognitive needs, e.g. acquired brain injury/fluctuating capacity
- people who are experiencing short or long-term illness
- people with long-term health conditions
- people who misuse substances or alcohol to the extent that it affects their ability to manage day-to-day living
- people providing unpaid care to a family member or friend
- an older person
- people who may appear to have needs that are not critical or substantial, but due to undue influence (inherent jurisdiction) may need extra help to manage their lives and be independent.

This is not an exhaustive list, but should be used as a guide to identify an individual with care and support needs. However, it is important to note that inclusion in one of the above groups does not necessarily mean that a person is implicitly unable to protect themselves from abuse or neglect.

9.3 Quality concerns

There is evidence that many issues raised as safeguarding concerns – such as falls, pressure ulcers, maladministration of medication or poor nutritional care – are rooted, not in malicious harm, but in poor practice and poor quality care.

The impact of this can be just as significant as intentional abuse. It is important to differentiate between the two, in order to address problems in the right way, so that all adults at risk receive safe, high quality care and support.

It is the provider manager's responsibility to ensure these are addressed proactively and effectively through internal processes and to ensure the service they provide meets the required standards of care. It is also important to avoid making safeguarding referrals unnecessarily, so that police and social workers are able to focus on potentially criminal acts and malicious behaviour rather than on poor care practices.

9.4 Recurring incidents

Poor care becomes a safeguarding issue when single instances of poor or neglectful care are repeated, patterns of harm are identified and other people are put at risk. Repeated instances of poor care may indicate serious underlying problems and can point towards organisational abuse, which occurs when standards of care are so poor throughout the entire care setting that adults are put at increased risk. The importance of recording everything – and regularly reviewing what has been recorded by everyone – cannot be over-stated.

Abuse and neglect can occur if risks are not identified or action taken to prevent further incidents occurring or the issue escalating. Incident logs should always be checked for trends that cause concern by those recording incidents and those responsible for monitoring the effective implementation of that organisation's incident policy.

Managers and staff have a duty to have systems in place that enable them to identify patterns or cumulative incidents and to raise a safeguarding concern if there are a number of these, even if these happened in the past once a trend is identified.

9.5 Considerations

Following current Careline processes, Careline should establish if the information relates to an adult at risk of abuse or neglect.

Does the initial information gathered suggest that the individual:

- has needs for care and support, and
- is experiencing, or is at risk of abuse or neglect, and
- unable to protect themselves because of those needs.

Does the information require further assessment for possible eligibility for care and support services?

What are the views and wishes of the adult?

What are the views/expectations of the referrer? Do they wish to raise a complaint, or a safeguarding referral?

9.6 Determining factors

Factors to be considered when determining whether the concern raised should be dealt with by a social worker or a provider will include:

- the care and support needs of the alleged victim
- capacity of the victim and alleged perpetrator
- balance/nature of power of the victim and alleged perpetrator
- the nature and extent of harm caused
- the frequency of incidents
- impact on the person
- their views and those of the family/friend/advocate if known
- are there any indicators that a crime may have taken place
- future risks of the individual
- are there any indicators that other adults or children are at risk?

9.7 Identifying quality concerns and safeguarding concerns

The examples below can be used as a general guide to support you in distinguishing between poor practice, which is a quality concern, and a safeguarding concern. Each situation is unique and needs to be risk assessed to take account of the particular circumstances, nature of the incident and seriousness, together with the wellbeing of the adult.

Area of concern	Concerns about the quality of practice which requires action by the provider service. Incident to be reported to Careline as a quality concern.	Safeguarding concern that requires a safeguarding enquiry. Possible abuse which requires reporting as such, and the instigation of safeguarding procedures
1. Failure to provide assistance with food/drink	Person does not receive necessary help to have a drink/meal. If this is an isolated incident, no harm has occurred and a reasonable explanation is given e.g. unplanned staffing problem, emergency occurring elsewhere in the home/community setting. Provider deals with this appropriately through internal procedures, to the satisfaction of the person involved. This would not be referred under the safeguarding adults procedures	Person does not receive necessary help to have drink/meal or support to maintain dignity and this is a recurring event, or is happening to more than one person. This constitutes neglectful practice; this may be evidence of organisational abuse and would prompt a safeguarding enquiry. The service user may have diabetes which may increase the risk of harm. Harm: malnutrition, dehydration, constipation, tissue viability problems.
2. Failure to provide assistance to maintain continence	Person does not receive necessary help to get to the toilet or maintain continence or have appropriate	Person does not receive necessary help to get to the toilet to maintain continence or support to maintain dignity and this is a

	assistance such as changed incontinence pads. If this is an isolated incident, no harm has occurred and a reasonable explanation is given e.g. unplanned staffing problem, emergency occurring elsewhere in the home/community setting. Provider deals with this appropriately through internal procedures, to the satisfaction of the person involved this would not be referred under the safeguarding adults procedures	recurring event, or is happening to more than one person – neglectful practice, this may be evidence of organisational abuse and would prompt a safeguarding enquiry Harm: pain, constipation, loss of dignity, humiliation, skin problems.
3. Medication not administered/Inappropriate medication administered/Person not receiving medication in accordance with code of practice /care plan	Person does not receive medication as prescribed or inappropriate medication is administered but no harm occurs. If this is an isolated incident and a reasonable explanation is given e.g. unplanned staffing problem, emergency occurring elsewhere in the home/community setting. Provider	Person does not receive medication as a recurring event, or it is happening to more than one person. Neglect of practice, regulatory breach, breach of professional code of conduct if nursing care provided. Prescribed medication being used to control the person's behaviour/not in accordance with the person's care plan/code of practice Harm: pain not

	deals with this appropriately through internal procedures, to the satisfaction of person involved this would not be referred under the safeguarding adults procedures	controlled, risk to health, avoidable symptoms.
4.Moving and handling procedures not followed/Provider has not provided appropriate equipment	Appropriate moving and handling procedures not followed but person does not experience harm. If this is an isolated incident and a reasonable explanation is given; provider deals with this appropriately through internal procedures, to the satisfaction of the person involved. This would not be referred under the safeguarding adults procedures.	One or more people experience harm through failure to follow correct moving and handling procedures Failure to maintain moving and handling equipment Neglectful practice – Harm: Pressure ulcers caused by shearing force.
5. Failure to provide support to maintain mobility	Person not given recommended assistance to maintain mobility and no harm has occurred. If this is an isolated incident and a reasonable explanation is given; provider deals with this appropriately through internal procedures, to the	Recurring event, or is happening to more than one service user resulting in reduced mobility. Harm: Risk of falls/tissue viability

	satisfaction of the person involved This would not be referred under the safeguarding adults procedures	
6. Inappropriate communication from staff - verbal/written	Person speaks in a rude, insulting, humiliating or other inappropriate way. The person spoken to is not distressed. If this is an isolated incident and a reasonable explanation is given; provider deals with this appropriately through internal procedures, to the satisfaction of the person involved This would not be referred under the safeguarding adults procedures	Person speaks in a rude, insulting, humiliating or other inappropriate way and the person is distressed or it happens to more than one person. Inappropriate written comments recorded about the individual/s in care plan and the individual/s is distressed Regime in the organisation doesn't respect service user's dignity and staff frequently use derogatory terms in written/oral communication.
7.Significant need not addressed in care plan/support plan/s not followed	Person does not have within their support plan a section that meets their needs or person's needs are specified in treatment or support plan and plan not followed but no harm occurs. If this is an isolated incident and a reasonable	Failure to specify in a service user's/ patient's support plan how a significant need must be met. Inappropriate action or inaction related to this results in harm such as choking after fluids etc. Failure to address a need specified in the

	explanation is given; provider deals with this appropriately through internal procedures, to the satisfaction of the person involved This would not be referred under safeguarding adults procedures	service user's health/ social care plan results in pain/harm. This is especially serious if it is a recurring event or is happening to more than one service user. Inappropriate use of restraint. Not seeking medical health/advice/support promptly/proactively
8. Inappropriate discharge from hospital	Patient is discharged from hospital without adequate discharge planning involving assessment for care /therapeutic services, procedures not followed but no harm occurs. If this is an isolated incident and a reasonable explanation is given; provider deals with this appropriately through internal procedures to the satisfaction of the person involved. This would not be referred under the safeguarding adults procedures.	Patient is discharged without adequate discharge planning, procedures not followed and patient experiences harm as a consequence. Harm: care not provided resulting in risks and/ or deterioration in health and confidence; avoidable re-admission to hospital.
9. Community care visit delayed/missed	Person does not receive a scheduled domiciliary care /District Nurse visit, and no other	Person does not receive scheduled care visit(s) and no other contact is made to check on their wellbeing resulting in

	contact is made to check on the service user's wellbeing, but no harm occurs. If this is an isolated incident and a reasonable explanation is given; provider deals with this appropriately through internal procedures, to the satisfaction of person involved. This would not be referred under the safeguarding adults procedures.	harm or potentially serious risk to the person. Safeguarding procedures should be instigated.
10. Pressure area management See appendix D for further guidance		Avoidable harm e.g. Person is frail and has been admitted without formal assessment with respect to pressure area management (or plan not followed). Care provided with no reference to specialist advice re: diet, care or equipment. Pressure damage occurs. Neglectful practice, breach of regulations and contract, possible organisation abuse. Safeguarding procedures should be instigated. Harm: avoidable tissue viability problems.
11. Falls See appendix E for further guidance.		Avoidable Harm/Neglect A person sustains an injury due to a fall and

		there is concern that a risk assessment was not in place or was not followed. Harm: physical injury service user has experienced avoidable harm
12. Abuse of a service user by another service user		Predictable and preventable (by staff) incident between two adults at risk occurs where bruising abrasions or other injury has been sustained and emotional distress caused. Harm: physical injury, psychological distress

9.8 Incidents between service users

Sometimes 'one-off' low level incidents do occur between service users. Where no harm has occurred, and it is an isolated incident, and the incident has been dealt with promptly by the provider to the satisfaction of the person involved, there would be no need to refer the incident under the safeguarding adults procedures. (See appendix C responding to incidents between service users.)

9.9 Pressure area management

Unavoidable pressure sores. Where a person known to be at high risk of developing pressures sores even though the provider has followed the risk assessment/care plan, and taken all appropriate actions. This does not need to be reported under the safeguarding adult procedures. (See appendix D pressure ulcer guidance.)

9.10 Falls

Where there have been accidental falls and risk assessments are in place and have been followed. This does not need to be reported under the safeguarding procedures. (See appendix E guidance for responding to falls.)

If your are unsure if an incident should be raised as a quality concern or a safeguarding concern please ring Careline 0151 233 3800 for further advice

9.11 Response to quality concerns

If the quality concern is a self-referral from a provider, Careline will ask the provider what action they have taken to address the issue. If Careline are satisfied that the issue has been addressed appropriately by the provider, Careline will close the quality concern and record the information on Liverpool city council management information system, including the outcomes of the concern. Careline will send a notification to the relevant social worker.

If the quality concern is from a service user or family member, Careline will determine if this is a complaint about a service and advise them of the recourses available to resolve their issue/s including the use of the complaints procedure.

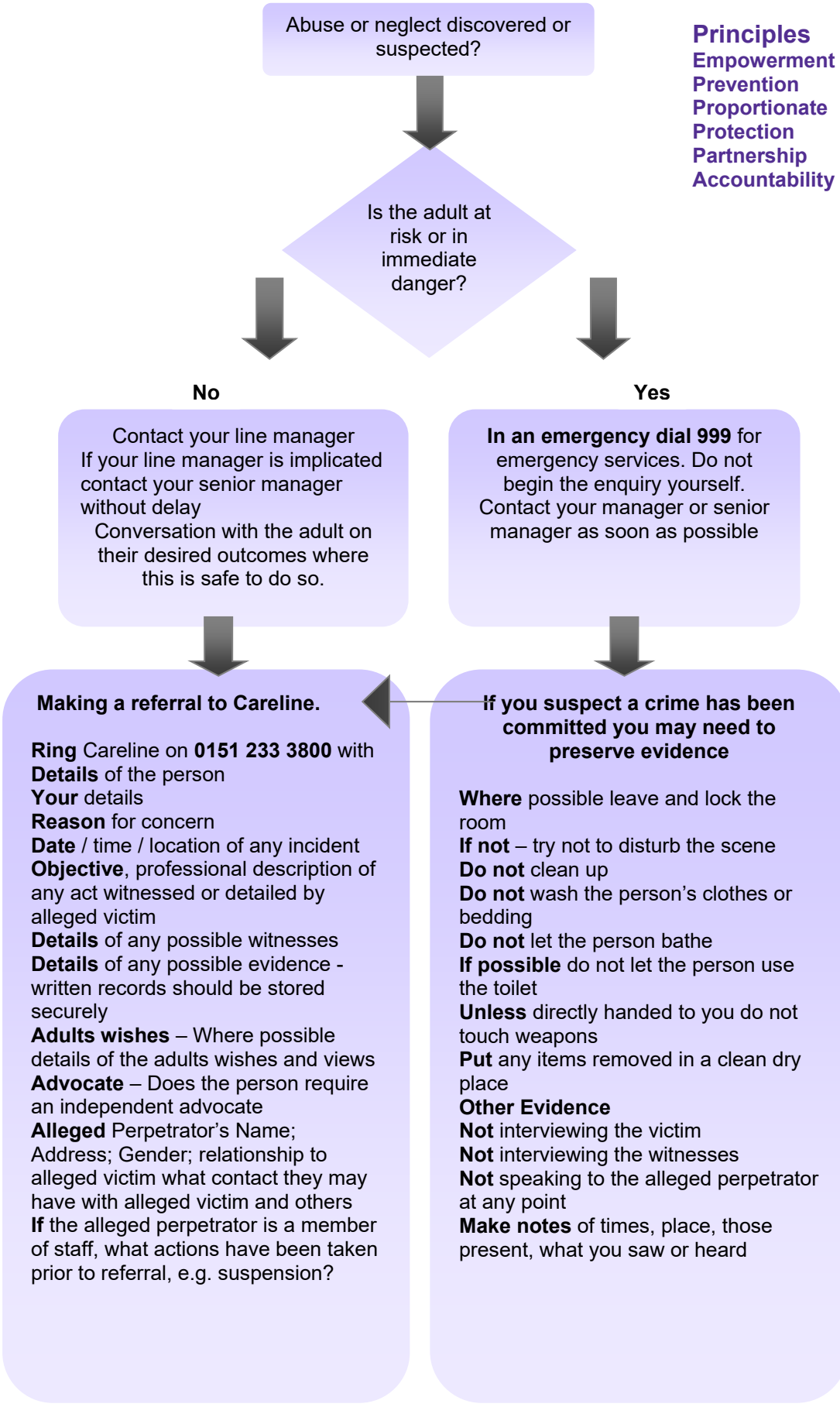
When a professional identifies a quality concern by a provider service they should speak to the provider directly and record the conversation in the person's records, so that appropriate action can be taken to rectify the concern. The professional should also report what action they have taken with Careline. If this is a repeated occurrence they should make a safeguarding referral to Careline.

In Liverpool we have robust systems and procedures for monitoring quality and safeguarding concerns. All provider quality concerns will be monitored by the quality assurance group which includes senior members from the local authority, Liverpool Clinical Commissioning Group and Liverpool Community health. (See Appendix G overview of quality assurance process)

Part 2 Procedures, roles and responsibilities in adult safeguarding.

Part 2 describes Liverpool's procedure, roles and responsibilities for reporting and responding to abuse or neglect of an adult with care and support needs and who because of those needs is unable to protect themselves.

10. What to do if you suspect abuse or neglect and how to report a safeguarding concern



10.1 Reporting a safeguarding concern

This section describes the procedure for reporting a safeguarding concern, the considerations and immediate actions necessary when adult abuse is disclosed, occurring, suspected or witnessed.

10.2 Who can report a safeguarding concern?

Anybody can raise a safeguarding concern for themselves or another person. Often abuse and neglect can be prevented from occurring in the first place if issues are identified and raised as soon as they arise so that they can be addressed at the earliest point. Those working with adults (paid or unpaid) have specific professional, and organisational and legal responsibilities to ensure where there is a safeguarding concern, that this information is shared with **Careline 0151 233 3800** and other organisations appropriately.

10.3 Anonymous reporting

It is preferable to know who is reporting a concern. It can make it more difficult to follow up concerns if the identity or contact details of the referrer are not known. Workers in paid or unpaid positions should always be expected to state who they are when reporting concerns. However, if the identity of the referrer has been withheld, the adult safeguarding process will proceed in the usual way. This will include information being recorded as an adult safeguarding concern

10.4 Consent and involvement of the adult in reporting the safeguarding concern

Adults have a legal right to make decisions about their lives. Wherever possible gain the consent of the individual and seek their views unless doing so is likely to increase the risk to them or put others at risk. Integral to effective person-centred approaches to adult safeguarding is engaging the adult in a conversation about how best to respond to their situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. Engaging with the adult in a meaningful way, at an early stage, is key to promoting good person-centred practice.

From the very first stages of concerns being identified, the views of the adult should be gained. This will enable the person to give their perspectives about the potential abuse or neglect concerns that have been raised, and what outcomes they would like to achieve. These views should directly inform what happens next.

There will be occasions where speaking to the adult could put them at further or increased risk of harm. This could be, for example, due to retaliation, or a risk of fleeing or removal of the adult from the local area, or an increase in threatening or controlling behaviour if the person causing the risk of harm were to know that the adult had told someone about the abuse or neglect, or that someone else was aware of it.

The safety of the adult and the potential for increasing the risk should always be considered when planning to speak to the person. Any such situations where there is the potential for endangering safety or increasing risk should be assessed carefully and advice taken from your line manager.

10.5 When an adult does not want information shared and there is a professional responsibility to do so

Where an adult with capacity to make an informed decision about their own safety does not want any action taken, this does not override a professional's responsibility to raise a safeguarding concern and to share key information with relevant professionals e.g. where others are at risk or a crime has been committed.

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

In these situations the adult must always be:

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

10.6 Where an offence may have been committed

If it is suspected that an offence may have been committed, there should always be a conversation with the adult regarding whether they wish the police to be involved.

If the adult does not want the police to be involved this does not override a professional's responsibility to share information regarding a potential or actual offence with them.

Such situations should always be approached sensitively. The adult should be advised that the police will be contacted, and assured that the police will be

informed that they do not wish to pursue this matter or speak to the police. It is for the police to determine if they feel it is necessary for them to speak to the adult, or if there is further action they may need to pursue.

10.7 Adults who lack capacity to make relevant decisions

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

10.8 Procedure for reporting a safeguarding concern

If something happens to you, or someone you know or are working with, or you see or hear about something which could be adult abuse do the following:

- in an emergency you must dial 999 for either the police or ambulance services. You do not have to wait for permission from your line manager to do this
- where appropriate action should be taken to prevent harm, however, **YOU MUST NOT PUT YOURSELF AT RISK**
- where appropriate talk to the adult as soon as possible unless this would put them, others or you at risk, about what they want to happen, what action they do or do not want taken, or want to take themselves
- if you are a member of staff, explain your responsibility to share information or raise a safeguarding concern
- follow your organisations procedures for reporting safeguarding concerns to the local authority
- contact Careline 0151 233 3800.

You are:

- not asked to verify or prove that information is true
- required to log your concerns and report them to an appropriate person for example your manager/the person in your organisation who is responsible for referring the safeguarding concern to the local authority
- expected to make a referral directly to Careline 0151 233 3800 if you are an autonomous practitioner.

Only the police have the responsibility to establish if a criminal offence has been committed.

Reporting a safeguarding concern through the formal channels will enable a proper assessment or enquiry to be co-ordinated. This will avoid any confusion or conflict between complaints, disciplinary and safeguarding processes.

All those making a complaint or allegation or expressing a concern, whether they are staff, service users, carers, members of the public, can be reassured that:

- they will be taken seriously
- their comments will be treated confidentially but their concerns may be shared if they or others are at risk
- if they are a service user action will be taken to minimise the risk of further abuse, reprisals or intimidation
- if they are staff they will be given support and afforded protection if necessary e.g. under the Public Interest Disclosure Act 1998; Crime & Disorder Act 1998, s. 115
- if a concern is raised in good faith they will be supported whatever the outcome of the enquiry
- they will be dealt with fairly and in a non-discriminatory manner
- they will be kept informed of action that has been taken and its outcome as far as possible.

10.9 You will not be criticised for following procedure

Failure to report a concern, allegation or disclosure will be viewed extremely seriously and may result in any or all of the following:

- criticism of your practice
- disciplinary action
- suspension
- dismissal
- a report being forwarded to your professional body.

10.10 Any such failure will be regarded as colluding with the abuse

If you suspect a crime has been committed you may need to preserve evidence for forensic examination, so avoid touching/moving objects or furnishings and request a forensic medical examination and treatment of any injuries/conditions before any other intervention.

NB - The victim is the primary crime scene and should be treated as such. (See page 55 - Flow chart how to raise an adult safeguarding concern.)

In all cases of concern, allegation or disclosure of abuse you must inform your manager/person within your organisation responsible for referring safeguarding concerns to the local authority as soon as possible.

If you suspect your manager is involved in the abuse you must report to a senior manager as soon as possible.

If someone makes an allegation or discloses abuse to you, you must make a note as soon as possible of what they said. Make sure that you use the person's own words.

You must never keep secrets, even if the person asks you not to tell anyone else. You must always share concerns, allegations or disclosures with your manager/person within your organisation responsible for reporting safeguarding concerns to the local authority.

10.11 Co-operation

You will be expected to co-operate with the enquiry. You may be required to provide a statement, attend a strategy meeting or be interviewed by the police.

Do not discuss what has happened with members of staff who have no direct involvement in the situation.

If a family member is raising the concerns you should explain the safeguarding process to them and the next steps. If the family is unaware of an incident you should take advice in relation to the appropriate timing of sharing information with them.

10.12 Making a referral

The person responsible for making the referral to Careline to raise a safeguarding concern should wherever possible provide the following information:

Allegation / Concern

- details of the person
- details of the person raising the concern
- reason for concern
- date / time / location of any incident
- location of victim
- details of the person's views and wishes if known/what the person wants to happen and if they have given consent for you to contact adult social care. If you do not know the adult's views, the reason you were not able to talk to them (this should only be if there was a concern that this might put them or others or you at risk)
- if the person has 'substantial difficulty' understanding/being involved with the enquiry
- details of family or a friend who can support the individual
- if the person requires an independent advocate
- objective, professional description of any act witnessed or detailed by alleged victim

- details of any possible witnesses
- details of any possible evidence - written records should be stored securely.

Alleged perpetrator

- name
- address
- gender
- relationship to alleged victim
- location of the perpetrator at the time of the referral if known
  what contact they may have with alleged victim and / or others
- if the alleged perpetrator is a member of staff, what actions have been taken prior to referral, e.g. suspension?
- If the alleged perpetrator is another service user if they require an independent advocate.

10.13 Responding to disclosure

- incidents of abuse or crimes may only come to light because the abused person tells someone
- the person may not consider that they are being abused when they tell you what is happening to them
- disclosure may take place many years after the actual event
- disclosure may take place when the person has left the setting where the abuse took place
- even if there is a delay, the information must be taken seriously
- reassure the person that you are taking what they say seriously.

If someone makes an allegation or discloses abuse to you:

DO

- stay calm and try not to show shock
- listen carefully
- be sympathetic
- tell the person that:
  - telling you was the right thing to do
  - you will treat the information seriously
  - it was not their fault
  - you will have to report the information to your manager/Careline
- write down what the person said to you as soon as possible and actions taken by you and others

- if known what the adults views of the incident are, and what they want to happen and if they have given consent for you to contact Careline.

DO NOT

- question the person about the incident
- ask the person who, what, why, where, when questions. This is the role of the police
- promise to keep secrets
- destroy any evidence
- make promises that you cannot keep, for example, 'This will not happen to you again'
- confront anyone who is thought to be responsible for what has happened, and do not tell them that concerns have been raised about them
- be judgmental, for example, 'why didn't you run away?'
- gossip about the incident.

When in doubt seek advice from your manager.

10.14 What happens next?

When the local authority receives a safeguarding concern they will check to see if they already have information that would help determine how best to support the adult and address any immediate risks. This will take account of the adult's wishes and what they want to happen, as far as this is known.
If the criteria for a safeguarding enquiry is met, the local authority has a duty to make enquiries or cause an enquiry to be made.

10.15 What is an enquiry?

An enquiry is an action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate right through to a multi-agency agency plan or course of action.

If the local authority does not have enough information to determine if the criteria for an enquiry is met, but still has a concern that the adult may be or is experiencing abuse or neglect they will make informal enquiries. This will include talking to the adult at the earliest point or asking another organisation to do so if this would be more appropriate.

If this resolves the concern or it becomes clear there are no grounds for concern or further action, the local authority's duty to make enquiries ends here. This will always take account of the adult's wishes, any risks to other adults, and other action that may be required.

11. An overview of the local authority's response to concerns about abuse or neglect

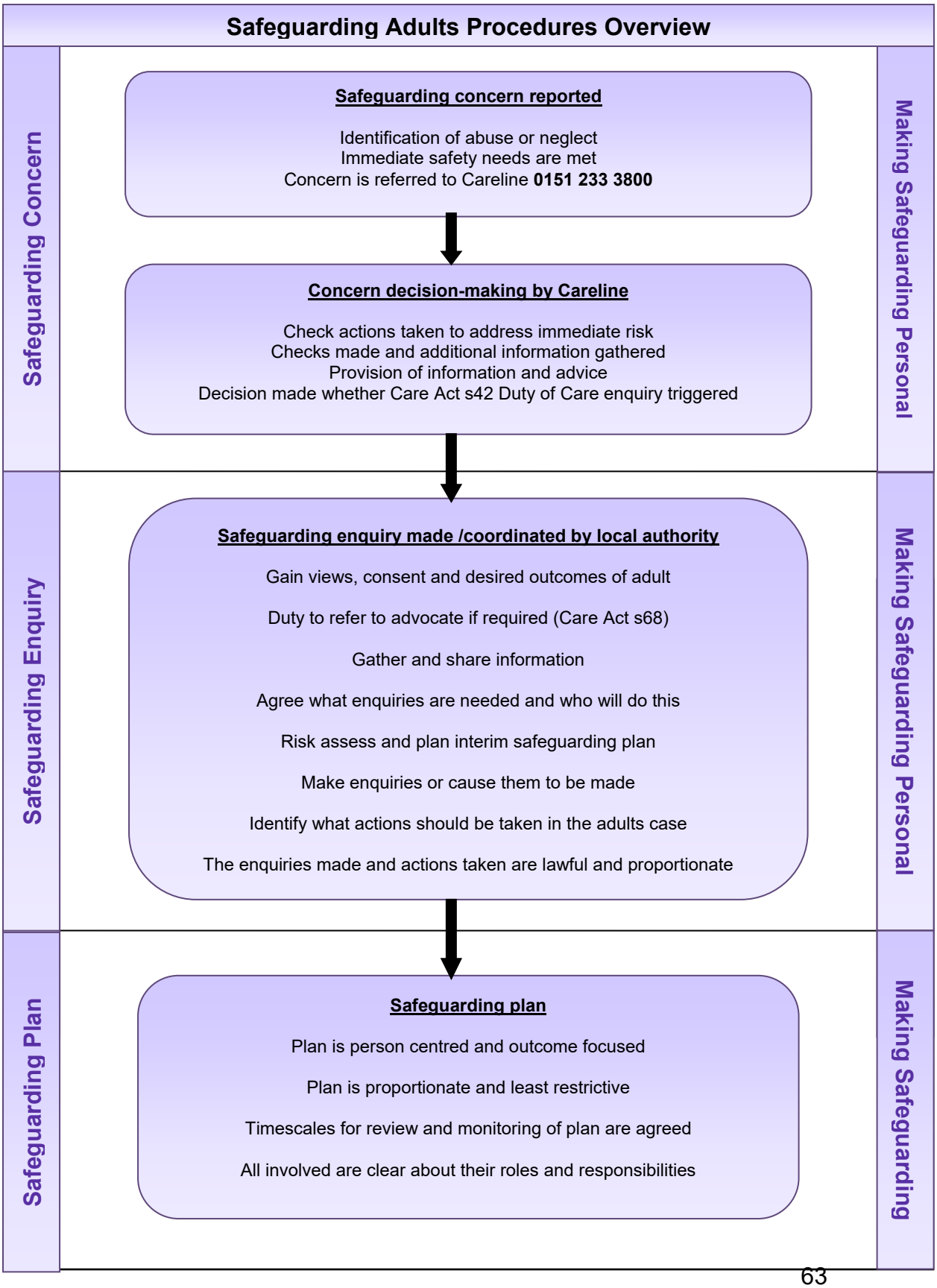
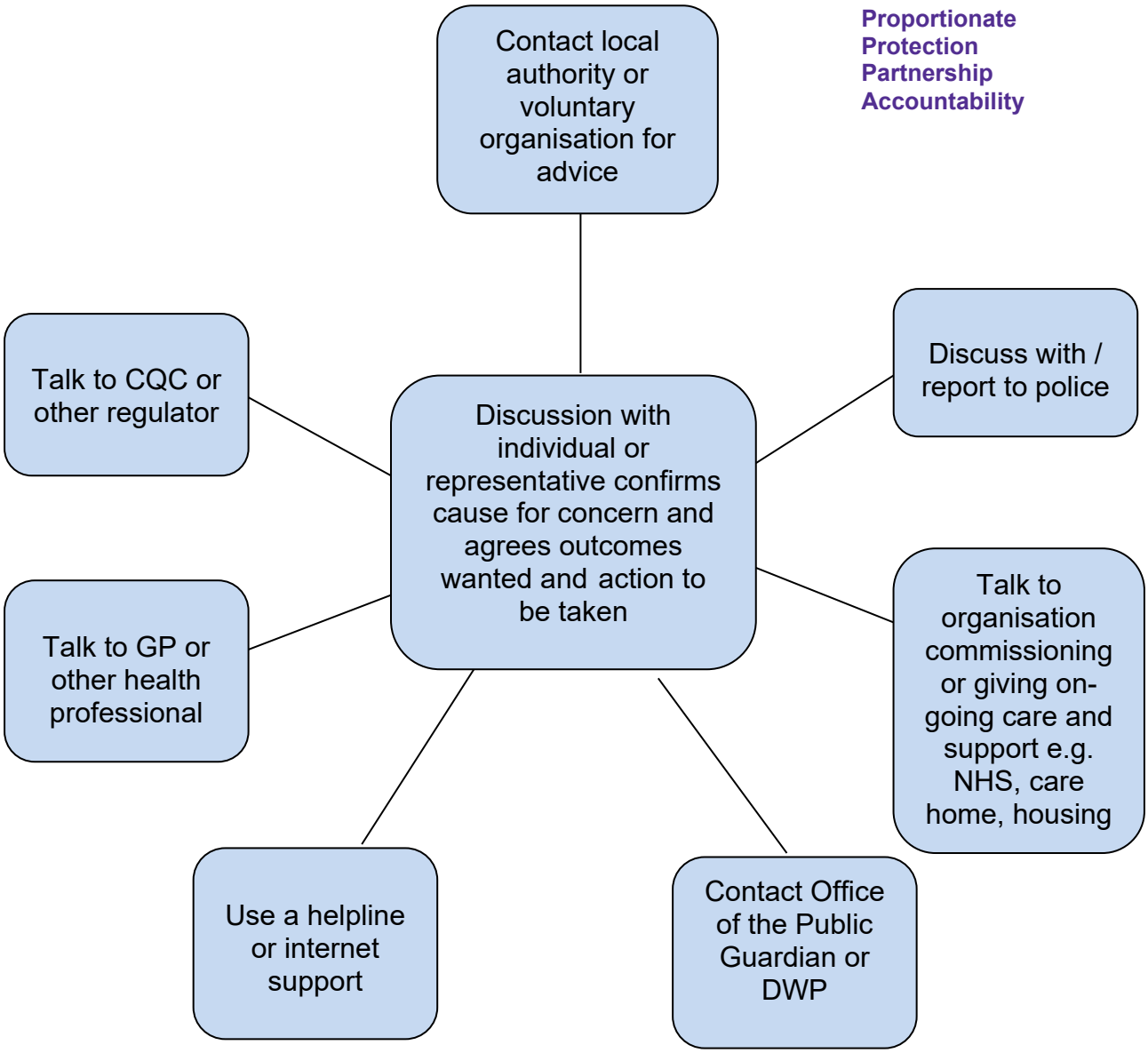


Diagram 1A
Information Gathering

Principles
Empowerment
Prevention
Proportionate
Protection
Partnership
Accountability



If the issue cannot be resolved through these means or the adult remains at risk of abuse or neglect (real or suspected) then the local authority's enquiry duty under section 42 continues until it decides what action is necessary to protect the adult and why whom and ensures itself that this action has been taken. See page 63 overview of safeguarding concern/enquiry

11.1 Careline adult services

This section explains the role of staff in Careline with responsibility for dealing with adult safeguarding concerns. As soon as a concern is reported, staff in Careline will ascertain the adult's safety. The decision to carry out a safeguarding enquiry does not depend on the person's eligibility to receive local authority services but should be taken wherever there is reasonable cause to think that the person is experiencing, or is at risk of, abuse or neglect.

The local authority staff receiving or identifying information that could indicate there is a 'safeguarding concern' will undertake basic checks with reference to any pre-existing relevant information, as they would for any other information or referral received.

If the information received and / or identified through this initial basic checks stage appears to indicate the adult affected meets the criteria below then the information should be treated as a 'safeguarding concern' and the local authority's duty to undertake an enquiry or cause others to do so is triggered. This could range from a conversation with the adult or if they have substantial difficulty understanding the enquiry their representative or advocate to a more formal multi-agency plan or course of action.

Criteria for a safeguarding enquiry under s.42 of the Care Act 2014

An adult:

- has needs for care and support (whether or not the authority is meeting those needs) and
- is experiencing, or is at risk of abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or the neglect or the risk of it.

11.2 Carers and safeguarding

An unpaid carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with. Unpaid carers are also covered by these procedures where the criteria above is triggered.

11.3 Where it is unclear if the adult is covered by the criteria in the Care Act

If Careline decides it is appropriate to undertake an enquiry but it is unclear whether the adult meets the criteria for an enquiry under the Care Act, it should be assumed the adult meets the criteria until further information is

available to inform this decision, or until the safeguarding concern is addressed.

Once it has been established that an enquiry under s.42 of the Care Act 2014 has been triggered social work staff in Careline will either forward the enquiry onto a social work manager to allocate to a social worker or will ask the commissioned provider organisation to undertake the enquiry.

Careline will take account of the information it already has, does not have, or requires, in order to determine the most appropriate response to the safeguarding concern. This must include consideration of:

- any immediate risk to the adult or others
- the adult's wishes
- the adult's capacity, representation and advocacy issues
- any risks and protective factors for the adult
- any risks and protective factors for others.

If the action undertaken through the 'enquiry' at this point results in it being established that:

- this is not a 'safeguarding concern' or
- the safeguarding concern has been resolved and
- the adult is no longer at risk of abuse or neglect (real or suspected).

then the local authority's duty under Section 42 will have been discharged and the enquiry is concluded at this.

11.4 Enquiry undertaken by a commissioned provider directed by a local authority social worker

If a situation meets the criteria for a safeguarding enquiry and in addition also meets the following criteria:

- involves a single agency
- is less complex
- does not involve a possible crime
- where the adult has not had previous safeguarding concerns raised
- LCC does not have any overarching concerns with the provider agency
- does **not** require a social worker to visit.

Careline will ask the provider agency to complete a safeguarding enquiry covering the specific issues outlined by the social worker.

Before a provider is asked to undertake a safeguarding enquiry Careline will ascertain if the adult:

- has capacity to make a decision regarding the safeguarding enquiry
- has 'substantial difficulty' understanding and being involved in the safeguarding enquiry
- if the adult has a relative or friend to support them during the enquiry
- the views and wishes of the services user.

If the adult lacks capacity or has 'substantial difficulty' understanding and being involved in the safeguarding enquiry and they have no one suitable to support them, Careline will make a referral for an advocate.

Please click on the link below to make a referral to Advocacy Experience for an independent advocate:

http://www.advocacyexperience.com

Careline will determine the:

- nature, scope and purpose of the enquiry the provider organisation is being asked to undertake
- the outcome the adult is seeking from the actions or enquiry, how the adult will be advised of progress and the outcome, who will be the lead professional responsible for communicating with the adult
- timescale for the enquiry.

The provider agency will then undertake an internal enquiry and complete an enquiry outcome provider report that outlines the findings of their enquiry, method of enquiry how the adults outcomes have been achieved and if not why not and any recommendations they have implemented. (See appendix F safeguarding enquiry outcome provider report.)

This report should be marked as confidential and posted to the Quality Assurance and Adult Safeguarding Unit (QAASU), Postal Address: Municipal Buildings, Dale Street, Liverpool L2 2DH or emailed to: SALEVEL1@liverpool.gcsx.gov.uk within 14 days of receipt.

The QAASU will quality assure the response to ensure the enquiry has covered all of the relevant concerns and if the adult's outcomes have been met. Where this is not the case, the provider will be asked to carry out further enquiries.

If the responses are satisfactory then QAASU will close the referral on LCC management information system and record the outcome of the enquiry.

11.5 Reporting safeguarding concerns to CQC

Careline will report all safeguarding concerns regarding regulated care setting to CQC.

Care Quality Commission:

Tel: 0300 061 6161 **Fax: 0300 061 6171**

Email: Enquiries@cqc.org.uk

Where Careline identify that a safeguarding enquiry needs to go to a social worker, the referral will be forwarded to the relevant team manager to allocate.

Every enquiry undertaken under Section 42 of the Care Act 2014 will have a manager appointed. The manager is responsible for overseeing the safeguarding enquiry, ensuring the local authority's duty under Section 42 of the Care Act is discharged appropriately.

11.6 Principles and approach underpinning all responses to safeguarding concerns

All responses to safeguarding concerns by the local authority, or commissioned provider organisations, must always be underpinned and informed by the six key safeguarding principles see page 10.

All responses to safeguarding concerns should involve a conversation with the adult or their representative or advocate if the adult has substantial difficulty understanding the enquiry. The conversation should take place at the earliest opportunity, and, as the enquiry progresses, in order to establish the adults wishes.

All other concerns that do not warrant a safeguarding approach will be forwarded to adult service complaints.

12. The role and responsibilities of managers from commissioned provider services in safeguarding adults from abuse or neglect

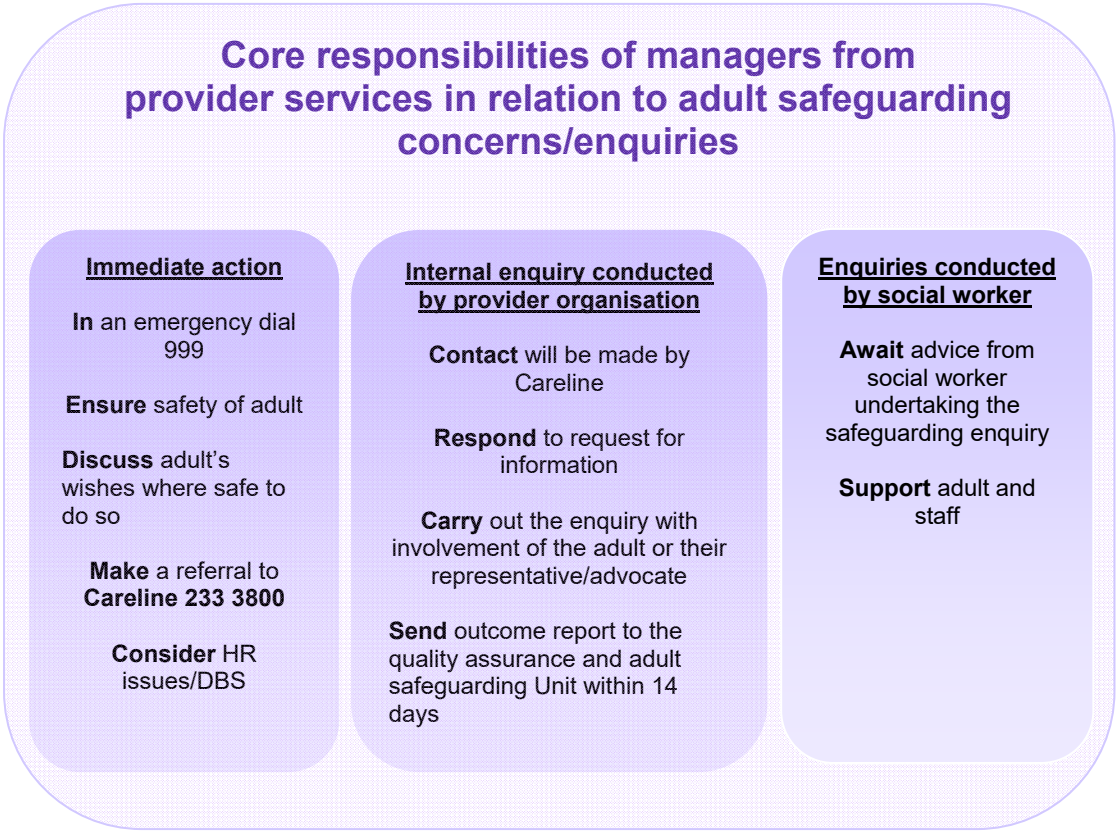
This section explains the responsibilities of commissioned provider agencies in relation to adult safeguarding, including the Care Act statutory guidance and the responsibility for reporting and responding to safeguarding concerns. This section should be read in conjunction with relevant sections of the safeguarding policy and procedures.

Provider agencies should produce for their staff a set of internal guidelines which relate clearly to the multi-agency policy and which set out the responsibilities of all staff to operate within it. These should include guidance on:

- identifying adults who are particularly at risk
- recognising risk from different sources and in different situations and recognising abusive or neglectful behaviour from other service users, colleagues, and family members
- routes for making a referral and channels of communication within and beyond the agency
- organisational and individual responsibilities for whistleblowing
- assurances of protection for whistle blowers
- working within best practice as specified in contracts
- working within and co-operating with regulatory mechanisms
- working within agreed operational guidelines to maintain best practice in relation to:
    - challenging or distressing behaviour
    - personal and intimate care
    - control and restraint
    - gender identity and sexual orientation
    - medication
    - handling people's money and
    - risk assessment and management.

Source: Care Act Statutory Guidance 14.205

12.1 Provider services



12.2 Generic procedure for all incidents of abuse

The following relates to incidents which would not constitute an emergency.

In an emergency you must dial 999 for the police and/or ambulance services.

In all other circumstances you must follow the guidance.

If an adult is at risk of or experiencing abuse or neglect you must contact:

Careline: 0151 233 3800

If you are raising a safeguarding concern, you must give all relevant information including the adult's desired outcomes any other organisations you have contacted.

12.3 Information for making a referral

The quality of information given when making a referral is very important (see section 10).

12.4 Care Quality Commission (CQC)

If your organisation is registered with CQC you must complete a Regulation 18 (2) to inform them of the incident. You can contact CQC:

Tel: 0300 061 6161 **Fax: 0300 061 6171**

Email: Enquiries@cqc.org.uk

12.5 Suspension of staff

If a member of your staff or volunteer is the alleged perpetrator you have a responsibility to risk assess the situation and decide if suspension is appropriate or not in the given circumstances. The decision to suspend must be your decision and must be done in line with your internal employment policies and procedures.

The police have the responsibility to determine if a crime has been committed. If the police are pursuing a case through the criminal justice route you should negotiate with the police as to when it is appropriate for internal disciplinary proceedings to begin.

A co-ordinated / negotiated approach will help to ensure the best outcome for both the criminal process and internal disciplinary processes.

12.6 Disclosure and Barring Service

An employer or volunteer manager must make a referral to the Disclosure and Barring Service (DBS) if the following criteria have been met:

- they have dismissed or removed the person from working with children or adults at risk of abuse or neglect (or would or may have done so if they had not left or resigned etc); because
- the person has engaged in relevant conduct in relation to children and/or adults at risk of abuse or neglect i.e. an action or inaction (neglect) that has harmed a child or adult or put them at risk of harm or
- satisfied the harm test in relation to children or adults at risk of abuse or neglect i.e. there has been no relevant conduct (i.e. no action or

inaction) but a risk of harm to a child or adult at risk of abuse or neglect still exists.

Further information regarding the disclosure and barring service can be found by accessing the link below:

https://www.gov.uk/government/publications/dbs-referrals-form-and-guidance

12.7 Record keeping

You must keep accurate records of the incident and action taken, see section 17.

12.8 Strategy meetings

You **may** be asked to attend a strategy meeting (see section 15).

12.9 Delegating responsibility in the manager's absence

Arrangements must be made for acting managers/senior carers to follow the guidance in the absence of a manager.

12.10 Internal safeguarding enquiries conducted by provider organisation which has been directed by a local authority social worker

Careline gathers and reviews the initial information.

If it is a situation that meets the criteria for a safeguarding enquiry and in addition also meets the following criteria:

- involves a single agency
- is less complex
- does not involve a possible crime
- where the adult has not had previous safeguarding concerns raised
- LCC does not have any overarching concerns with the provider agency
- does **not** require a social worker to visit.

Then we will ask the provider agency to complete the safeguarding enquiry outcome provider report covering the issues outlined by Careline. (See appendix F safeguarding enquiry outcome provider report.)

Making Safeguarding Personal (MSP) is integral to the safeguarding enquiry and the provider agency carrying out the enquiry must consult and involve the adult or, where relevant, their representative or advocate as the enquiry progresses. (See section 3 Making Safeguarding Personal.)

If the adult has 'substantial difficulty' understanding the enquiry and has no one suitable to support them, Careline will make a referral for an independent advocate to support the adult. The independent advocate will make direct contact with you.

Advocacy Experience website:

Available at: http://www.advocacyexperience.com

12.11 Provider response

The provider agency will then complete an internal safeguarding enquiry and provide a report that outlines the findings of their enquiry, how the adults outcomes were met, and their conclusion and any recommendations they have implemented. This will include details of discussions with the service user or their representative or advocate.

This report should be emailed using a secure email address and sent to: SALEVEL1@liverpool.gcsx.gov.uk or marked as confidential and posted to the Quality Assurance and Adult Safeguarding Unit (QAASU), Postal Address: Municipal Buildings, Dale Street, Liverpool L2 2DH within 14 days of receipt.

The QAASU will quality assure the response and ensure the enquiry has covered all of the relevant concerns and the adult's outcomes. Where this is not the case, the provider will be asked to carry out further enquiries.

If the responses are satisfactory then QAASU will close the referral on LCC's management information systems and record the conclusion and outcome/s of the enquiry.

13. The role and responsibilities of team leaders/managers from commissioning, social work and integrated team in safeguarding adults from abuse or neglect

This section explains: the role of the team leader/manager in relation to an adult safeguarding enquiry, the considerations to be taken into account when receiving a safeguarding referral, risk assessing the information, the adult's views and wishes if known, allocation of the safeguarding enquiry right through to closure of the safeguarding enquiry.

Whilst work with the adult may frequently require the input of a social worker, other aspects of enquiries may be best undertaken by others with more appropriate skills and knowledge. For example, health professionals should undertake enquiries and treatment plans in relation to medicines management or pressure sores.

If the safeguarding enquiry relates to dentists, opticians and pharmacies you should consider NHS England. For NHS services, other than those mentioned above, you should consider Liverpool Clinical Commissioning Group.

13.1 Core responsibilities for team leaders / managers

On receipt of referral

Risk assess the information

Interrogate internal systems

Allocate referral to social worker

Assess urgency of response/visit

Consider adult's wishes and views if known

Document all actions and decisions on Liquidlogic

Oversee/ensure

Agree initial actions identified by the social worker

Network discussions have taken place

You have received feedback from network discussions

Decide if further action is necessary

Set further review times / dates

Document all decisions taken

If the alleged perpetrator is a service user inform their social worker

Ensure

Wherever possible enquiries are to be completed within the time frame allowance

Social Worker undertaking the enquiry has closed the enquiry appropriately

Incidents are closed on Liquidlogic

All parties involved in the enquiry or networking are informed that the case is closed

NB if another organisation is taking the lead in the enquiry**, the case is not closed until your team has received an outcome and it is closed on** Liquidlogic

It is the team manager's / team leader's responsibility to manage safeguarding enquiries.

13.2 The wider implications of a safeguarding enquiry

All enquiries should be of a forensic quality. At the beginning of an enquiry consideration should be given to the potential wider outcomes. The information /evidence gathered could become part of legal proceedings in the Crown Court, Magistrate's Court, High Court, Court of Protection or the Coroner's Court. The enquiry could form part of disciplinary proceedings or an industrial tribunal.

13.3 On receipt of a safeguarding adult referral

It is your responsibility to:

- establish the adult's capacity
- when capacity is determined, establish the adult's wishes, preferences etc
- establish if an independent advocate is required
- risk assess the information and assess the immediate safety and wellbeing of the adult.
- record that the adult is safe and the date on Liquidlogic
- allocate the referral to an appropriate social worker
- ensure that there is sufficient information available in order to assess the urgency of any response/visit
- agree initial actions identified by social worker
- build in further review dates with the practitioner responsible
- if the adult is not covered by this procedure a referral should be made to an appropriate service
- if the adult is already in receipt of services or an open case to assessment and care management this should not preclude a further enquiry
- if the alleged perpetrator is known to services their social worker / team manager should be informed.

13.4 Disclosure/sharing of information

Safeguarding adult enquiries have to sit alongside statute and other guidance. Enquiries should be transparent and ethical. It is not appropriate to conduct an enquiry without being transparent about the reasons why there is an enquiry being conducted. Depending on the circumstances it may be necessary to discuss the findings and the outcome with organisations or family members so that they are equipped with the relevant information to develop or be part of protection plans. You should inform relevant parties if you have requested input from an Independent Mental Capacity Advocate/Advocate.

- it is not appropriate to disclose who the alerter is
- information should not be disclosed to an alleged perpetrator
- all disclosure / sharing of information should be risk assessed. The sharing of personal information must always be discussed with your manager, legal services or data protection officers within the Authority and must not breach the Data Protection Act.

For further information please refer to disclosure of adult's information to third parties policy via the link below:

http://lccintranet.liverpool.local/organisation/directorates/adult-services-and-health/policies-and-guidance/

13.5 Court proceedings

For the purpose of court proceedings, a witness is competent if they can understand the questions and respond in a way that the court can understand. Police have a duty under legislation to assist those witnesses who are vulnerable and intimidated. A range of special measures are available to facilitate the gathering and giving of evidence by vulnerable and intimidated witnesses. Consideration of special measures should occur from the onset of a police investigation. In particular:

- immediate referral or consultation with the police will enable the police to establish whether a criminal act has been committed and this will give an opportunity of determining if, and at what stage, the police need to become involved further and undertake a criminal investigation
- the police have powers to initiate specific protective actions which may apply, such as Domestic Violence Protection Orders (DVPO)
- a higher standard of proof is required in criminal proceedings ("beyond reasonable doubt") than in disciplinary or regulatory proceedings (where the test is the balance of probabilities) and so early contact with police may assist in obtaining and securing evidence and witness statements
- early involvement of the police will help ensure that forensic evidence is not lost or contaminated
- police officers need to have considerable skill in investigating and interviewing adults with a range of disabilities and communication needs if early involvement is to prevent the adult being interviewed unnecessarily on subsequent occasions. Research has found that sometimes evidence from victims and witnesses with learning disabilities is discounted. This may also be true of others such as people with dementia. It is crucial that reasonable adjustments are

made and appropriate support given, so people can get equal access to justice

- police investigations should be coordinated with health and social care enquiries but they may take priority
- guidance should include reference to support relating to criminal justice matters which is available locally from such organisations as Victim Support and court preparation schemes
- some witnesses will need protection and the police may be able to get victim support in place.

13.6 Allocation of safeguarding enquiries

If the case is already open to a social worker you must consider whether it is appropriate that they automatically become the officer to undertake the safeguarding enquiry. An informal approach by a social worker who is well known to the person and their carer(s) may appear to be appropriate. However, an informal approach may overlook the seriousness of the situation. Similarly, a social worker becoming the enquiry officer may damage a positive and effective working relationship with an individual or family.

13.7 Networking

Gathering information is a crucial part of the decision making process (See diagram 1A page 64). You should oversee and agree the action plan with the allocated social worker dependent on the information gathered so far. **Please note networking can be done by telephone** and details of telephone calls/conversations must be recorded on the chronological sheet.

An example of the networking process would be as follows:

- there may be information regarding the adult and alleged perpetrator on Liquidlogic
- clarification of information from the referrer is necessary but contact should be **risk assessed** to ensure it is appropriate in each case
- if it appears a crime has been committed, discussions with the police are essential
- if the alleged perpetrator is an adult with needs for care and support, liaison with their care management team or a referral for that person should be made through Careline
- capacity and consent issues may need to be considered and a decision to involve an Independent Mental Capacity Advocate (IMCA)/advocate may be required
- in a regulated service discussions with the Care Quality Commission will be necessary
- in a service commissioned by the local authority, discussions with the contract manager will be necessary

- if part of the referral is a complaint, the adult services complaints team needs to be consulted
- in a service commissioned by the local authority, the Quality Assurance and Adult Safeguarding Unit (QAASU) could have information relevant to the case.

NB - If the referral relates to a care provider careful consideration of the facts established should be considered prior to any contact with them. This should be decided on a case by case basis. You should receive feedback from the networking process. The information gathered should inform further actions.

13.8 Strategy discussions

Every enquiry will need strategy discussions to decide who will lead the enquiry; what are safeguarding concerns; the adult's wishes and how the safeguarding enquiry needs to proceed etc. This discussion will include the manager allocating the referral and all relevant or potential agencies involved in the safeguarding enquiry; e.g. police, health, complaints section, etc. However, if there are a number of enquiries indicated, which may need to run concurrently, a formal strategy meeting will almost certainly be required.

REMEMBER – involvement and engagement with the adult throughout is key to promoting personalised approaches to adult safeguarding.

13.9 Strategy meetings

Decide if there is enough evidence to call a strategy meeting. If a strategy meeting is required, the team leader/manager must contact the relevant locality manager to discuss the outcome of the networking process, purpose of the strategy meeting and proposed attendees.

13.10 Managing the enquiry

You must supervise the work of the social worker throughout the enquiry.

You should ensure all actions and decisions are recorded including the decision not to take any further action.

In cases where the police are undertaking an investigation in relation to a safeguarding issue you must ensure that regular contact is maintained with the Protecting Vulnerable Persons Unit (PVPU), and ensure records are updated accordingly.

You must ensure a timely completion to the case.

You must ensure the enquiry has been closed appropriately:

- adult has been informed

- incident closed on Liquidlogic
- incident closed in case file and appropriate documentation placed in safeguarding section of the case file
- chronology sheet is complete and signed off
- sign off outcome report
- all those involved in the enquiry are informed that the case is completed and closed.

13.11 Timescales

Networking – wherever possible within 24 hours of receipt of referral.
Initial Strategy Meeting – wherever possible within five working days of receipt of referral.
Wherever possible the enquiry should be concluded – within 28 days of receipt of referral or 28 days of reconvened strategy meeting.

13.12 Closure of cases

It is essential that cases are closed appropriately. The authority has a statutory duty to send statistical returns to the Department of Health in relation to safeguarding adult referrals. (See appendix N safeguarding enquiry outcome report.)

Ensure that:

- **wherever** possible enquiries are completed within the timeframe
- **discussion** has taken place with the adult, or if they have substantial difficulty understanding, their representative or advocate in relation to the adult's desired outcomes and if they were met or not met
- **social worker** has closed the enquiry appropriately
- **incident** is closed on Liquidlogic
- **all** parties involved in enquiry/networking are informed that the case is closed.

Consideration must be given to who and how those involved in the enquiry are informed of the outcome/any recommendations and closure of the enquiry etc. Does this require individual face-to-face meetings or a multi-agency meeting with actions/recommendations, identified responsibilities for implementing actions and monitoring safeguarding plans?

NB - if another organisation is undertaking the enquiry, the case is not closed until your team has received an outcome and it is closed on Liquidlogic.

14. The role and responsibilities of the social worker/enquiry officer in safeguarding adults from abuse or neglect

This section explains the role and responsibilities of the social worker/enquiry officer in relation to adult safeguarding concerns/enquiries. The flow chart below provides an overview of the role of the social worker/enquiry officer when dealing with a safeguarding enquiry.

Allocation of safeguarding enquiry

Agree initial risk assessment and networking with team leader
Contact the referrer to clarify the information and safeguarding issues. This needs to be risk assessed first
Look on Liquidlogic for information in relation to adult and alleged perpetrator
Network with all relevant organisations (If a provider is implicated do not contact them at this point)

Adult

Gain views, consent and desired outcomes for adult
Establish if there are capacity issues for the adult, refer to advocate if required (Care Act s68)
Evidence reasons for continuing with safeguarding enquiry against the adult's wishes
Document all decisions and actions

Safeguarding enquiry

Set out the aims and objectives of the enquiry
Clarify what supporting evidence you would need
Clarify what assistance, if any, you may need and where to get it
Clarify who you may need to consult with
Plan the order of the enquiry
Plan your interviews
Ensure safeguarding plan in place and agree who will monitor and review
Document all decisions and actions
Ensure the enquiries made and actions taken are lawful and proportionate

THE ENQUIRY MAY HAVE A NUMBER OF STRANDS NEEDING CO-ORDINATION

Police investigation	Social care enquiry	Care Quality Commission investigation	Contracts led investigation	Disciplinary proceedings

STRATEGY MEETINGS
Complicated cases involving several strands of the enquiry may require a strategy meeting.
The meeting will evaluate risk and develop protection plans
Time Scales Strategy meetings should be held within **five working days**

CONCLUSION OF CASES
Cases should be concluded within **28 days**
Discussion with the adult and if their desired outcome/s were met
All organisations involved in the networking/enquiry must be informed the case is closed
Cases must be closed on Liquidlogic; the enquiry outcome report must be complete
If the enquiry is being made by another organisation – it is not closed until you have an outcome and it is closed on Liquidlogic

14.1 Adult's views and wishes

Wherever possible there should be a conversation with the adult at the earliest opportunity to establish:

- their views and wishes, what do they want to happen
- if the adult feels in immediate danger or at risk, and what they want to do about this or what protective factors they have put in place themselves
- what action, if any, the adult wants taken
- what outcomes the adult wants from the safeguarding enquiry.

Discussions with the adult should be maintained throughout the enquiry establishing what they want to happen, and if this has been achieved (see section 3 Making Safeguarding Personal).

Where the adult has 'substantial difficultly' being involved in the enquiry and has no one suitable to support them you must make a referral for an independent advocate.

Please click on the link below to make a referral to Advocacy Experience for an independent advocate:

http://www.advocacyexperience.com

14.2 What happens if the adult does not want any action taken?

Adults have a legal right to make decisions about their own lives. If the adult has capacity but does not want any action taken, their wishes should be respected wherever possible. However, there will be exceptions when a professional must override the adult's wishes e.g. when others are at risk of abuse or neglect, a breach of regulation, professional code of conduct of a criminal offence appears to have been committed.

Where there is a requirement to override an adult's wishes the adult must be informed of this and all information documented providing evidence of any alternative considered and the rationale for overriding the adult's wishes.

REMEMBER – involvement and engagement with the adult throughout is key to promoting personalised approaches to adult safeguarding.

14.3 The wider implications of a safeguarding enquiry

All enquiries should be of a forensic quality. At the beginning of a safeguarding enquiry consideration should be given to the potential wider

outcomes. The information / evidence gathered could become part of legal proceedings in the Crown Court, Magistrate's Court or the Coroner's Court. The safeguarding enquiry could form part of disciplinary proceedings or an industrial tribunal.

14.4 Disclosure / sharing of information

Safeguarding adult enquiries have to sit alongside statutory and other guidance. Enquiries should be transparent and ethical. It is not appropriate to conduct an enquiry without being transparent about the reasons why there is an enquiry being conducted. Depending on the circumstances it may be necessary to discuss the findings and the outcome with organisations or family members so that they are equipped with the relevant information to develop or be part of safeguarding plans. You should inform relevant parties if you have requested input from an independent advocate.

- it is not appropriate to disclose who the alerter is
- information should not be disclosed to an alleged perpetrator
- all disclosure / sharing of information should be risk assessed
- the sharing of personal information must always be discussed with your manager, legal services or data protection officers within the authority and must not breach the Data Protection Act.

For further information please see disclosure of service user's information to third parties policy which can be can be found via the link below

http://lccintranet.liverpool.local/organisation/directorates/adult-services-and-health/policies-and-guidance/

14.5 What the safeguarding enquiry will involve:

- on allocation establish wishes, preferences, wellbeing of adult
- ensuring support and care for person throughout the enquiry, keeping them informed, include advocates, family and representative
- where relevant ensure there is complete transparency during the enquiry
- establish status of referrer prior to clarifying information in referral
- planning an enquiry possibly in collaboration with other agencies
- ensure liaison with regulatory bodies where relevant e.g. the Care Quality Commission
- identifying supporting evidence which will need to be examined.
- coordinating the input of other agencies/professionals
- when necessary, assessing capacity and consent issues. This may need to be done in a multi-disciplinary forum

- deciding who is best placed to conduct interviews
- collating and evaluating information and evidence
- completing a risk assessment
- developing safeguarding plans
- documenting all actions and decisions on Liquidlogic.

14.6 The role of the social worker undertaking the safeguarding enquiry

- capacity, wellbeing issues to be considered
- make a referral for an independent advocate where required
- through discussion with the adult or where applicable their representative/advocate identify the service user's desired outcomes
- co-ordinate the different strands of the enquiry
- agree initial risk assessment(s) and networking with manager
- complete sufficient enquiries in order to make an initial assessment of the situation
- ensure network discussions take place with all relevant agencies
- complete a risk assessment
- establish the facts/identify who/where the allegations have come from
- maintain contact with the adult throughout the enquiry
- the networking discussions should inform the urgency of any response/visit
- ensure that all relevant agencies are kept in the information loop
- ensure there is transparency throughout the enquiry
- provide a verbal report to your manager by the end of the networking process and at other agreed intervals
- attend and provide a verbal report to strategy meetings when applicable
- develop safeguarding plans and agree who is responsible for monitoring and reviewing
- document all actions and decisions on Liquidlogic
- ensure all scanned documentation is legible and complete
- ensure the actions/recommendations/adult's outcomes in the enquiry outcome report have been undertaken and recorded on Liquidlogic
- ensure appropriate closure of case on Liquidlogic.

14.7 Networking

Gathering information is a crucial part of the decision-making process (see diagram 1A page 64). You should draw up an action plan with the agencies

involved in the enquiry dependent on the information gathered so far. **Please note networking can be done by telephone**. Details of telephone calls/conversations must be recorded on the chronology sheet.

14.8 Importance of contacting the police

If you think a crime may have been committed you must make a referral to the police. If you are in any doubt you must take advice from the Liverpool Protecting Vulnerable Persons Unit (PVPU). The PVPU terms of reference are to investigate possible offences which occur:

- within the family or extended family
- in respect of the person being cared for by any person (voluntary or professional) entrusted with the person's at the time of the alleged offence
- all allegations of physical, financial, sexual abuse and neglect where the complainant is an adult with care and support needs and because of those needs unable to protect themselves and the offence involves some aspect of abuse of trust, power or influence by the suspect
- all police recommendations to be discussed with manager.

You must consult with the police as early as possible in the safeguarding enquiry. This will assist gathering and preserving evidence.

Delay may result in forensic and other evidence being lost or diluted and statement evidence becoming contaminated. If you start the enquiry without first consulting the police you run the risk of contaminating possible evidence. If the police are involved at an early stage this evidence can be collected and preserved.

All police referrals must be emailed to the Liverpool Protecting Vulnerable Persons Unit (PVPU) at the address below:

Liverpool Protecting Vulnerable Persons Unit (PVPU)

Tel: 0151 233 2323 or 0151 233 2273

Email:Liverpool.MASH@merseyside.pnn.police.uk

Out of Hours - the above numbers are operative during office hours. Out of hours in a non emergency you must contact the police on 0151 709 6010.

14.9 Achieving best evidence

Special Measures were introduced through legislation in the Youth Justice and Criminal Evidence Act 1999 (YJCEA) and include a range of measures to support witnesses to give their best evidence and to help reduce some of the anxiety when attending court.

Measures in place include the use of screens around the witness box, the use of live-link or recorded evidence-in-chief and the use of an intermediary to help witnesses understand the questions they are being asked and to give their answers accurately.

If an Achieving Best Evidence interview is necessary the police will take the lead on this. You should take your lead from the police.

The police may establish, during their investigation that the complainant is likely to meet the criteria for consideration as a Vulnerable Witness (s.16, Youth Justice & Criminal Evidence Act, 1999) which means that they might be granted special measures e.g. screens, video-link, a supporter with them when giving evidence, etc.

Ministry of Justice - Achieving Best Evidence in Criminal Proceedings:

Available at:
http://www.cps.gov.uk/legal/assets/uploads/files/Achieving%20Best%20Evidence%20in%20Criminal%20Proceedings.pdf

Care Quality Commission (CQC) Safeguarding People Webpage:

Available at: http://www.cqc.org.uk/content/safeguarding-people

Telephone Contact for CQC: 0300 061 6161

14.10 ADASS cross boundary protocol

This agreement states that “the authority where the abuse occurred should always take the initial lead on the safeguarding 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 has been committed.”

ADASS Protocol for inter-authority safeguarding enquiries of adult abuse and neglect:

Available at:
http://www.adass.org.uk/images/stories/Safeguarding%20Adults/ADSS%20Cross%20Boundary%20Protocol%20-%20Jan%2005.pdf

14.11 The enquiry

An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate to a much more formal multi-agency plan or course of action.

All safeguarding enquires must be underpinned and informed by the six safeguarding principles: empowerment; prevention; proportionality; protection; partnership; and accountability. All enquiries should involve a conversation with the adult or where relevant their representative or advocate at the earliest opportunity. Discussions with the adult must be maintained as the enquiry proceeds.

It is important to think about the safeguarding enquiry procedure in order to ensure all relevant enquiries are made. Safeguarding adults is a multi-agency responsibility and when appropriate our partner organisations should be an integral part of enquiries.

You need to think about the following issues:

- has the initial referrer been contacted, has this been risk assessed
- have you ascertained the adult's views and wishes
- is there anything which suggests that a criminal act may have taken place – if yes, the police must be contacted
- are there clinical or specialist areas of the enquiry you may not have an understanding of – where will you get advice/information in relation to this?
- next step on the basis of the networking process a decision must be made whether a strategy meeting is necessary. Indicators to suggest that a strategy meeting is required may include but is not exclusive to:
    - serious complex cases
    - multi-agency involvement with an individual
    - several agencies have concerns and the sharing and pooling of information is desirable
    - several individuals are or could be at risk
    - there are indications that a number of safeguarding enquiries are being undertaken (or could be)
    - the seriousness of the incident.

You must be prepared to present your evidence and risk assessment at the strategy meeting

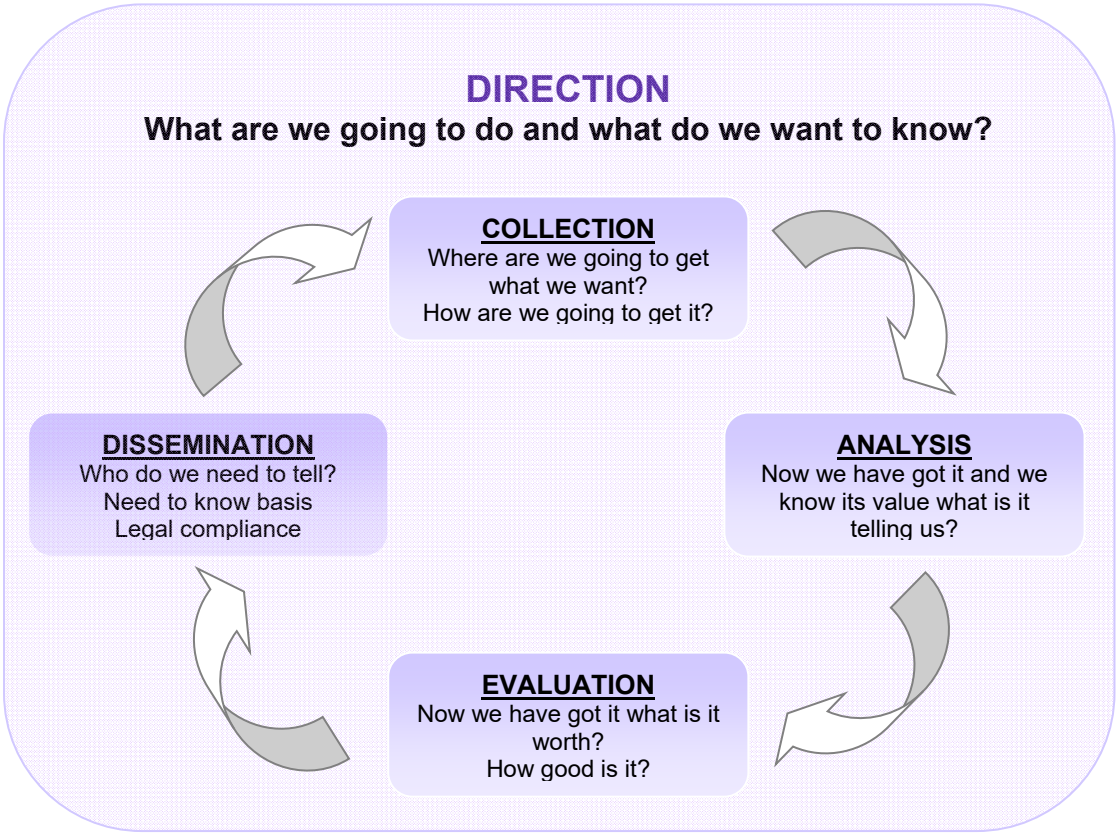
14.12 Evidence

Evidence can mean many things an example of which is:

- direct observation
- verbal statements
- physical evidence
- previous referrals
- criminal intelligence
- documentation – e.g. care plans, risk assessments, weight charts, turning
- clocks, fluid balance charts, etc.

14.13 The intelligence/investigation/enquiry cycle

The following diagram is a well-recognised process which helps to ensure a thorough enquiry which stands up to scrutiny. The direction assists with control of the enquiry, active planning, pro-active information gathering and if documented correctly scrutiny over rationale in decision making.



14.14 Working with partner agencies

The social worker undertaking the enquiry may need advice or assistance from other specialist organisations. Below is an example of the responsibilities of other key investigative organisations.

14.15 Liverpool Clinical Commissioning Group

Process for local authority staff requesting clinical support for a section 42 safeguarding enquiry in a care home setting

Social worker receives safeguarding referral with a clinical / quality issue or safeguarding concern that requires support from a clinician

- The referral to be sent to safeguarding service Liverpool Clinical Commissioning Group (CCG) and Liverpool Community Health (LCH) simultaneously through secure sites (see below). This will ensure the CCG safeguarding service has oversight of the health and quality concerns and themes of concerns of commissioned providers
- LCH safeguarding team to inform the CCG safeguarding service of terms of reference (TOR) for enquiry prior to visit, likely date to visit and LCH staff will proceed with the safeguarding enquiry visit
- CCG Safeguarding Service will review terms of reference (TOR) for the safeguarding enquiry by LCH, cross referencing CCG information and will request LCH safeguarding adults team include any additional TOR as required. It will be a CCG safeguarding service responsibility to inform LCH of any additions prior to any visit planned
- CCG Safeguarding Service will consider whether CMCSU are to be alerted re support / review of residents.

Clinical outcome of the safeguarding enquiry is to be fed back by LCH to the allocated social worker and CCG safeguarding service to maintain an overview of commissioned services. Information will also be provided by LCH as required at the local authority quality assurance group.
Where concerns require urgent action / further action the LCH safeguarding adults specialist nurse will take appropriate action to promote adult / client safety and will follow the inter-agency safeguarding adults policy and procedures. LCH will escalate to the CCG safeguarding service at the earliest opportunity

LCC QAASU (Quality Assurance and Adult Safeguarding Unit) to share action plans with CCG safeguarding service (LCH) where clinical issues are being monitored.

Single point of contact for safeguarding service referrals: ccg.adultsafeguarding@nhs.net

Single point of contact for CCG referrals: safeguardingadults.lch@nhs.net

Any direct safeguarding referrals the CCG safeguarding service receive will be referred to Careline as per multi-agency safeguarding adults policy.

14.16 Roles of other key investigators

Any criminal offence	Police
Regulatory issues defined by Health & Social Care Act 2008	Care Quality Commission www.cqc.org.uk
Serious incident in health setting	Care Quality Commission
Breach of rights under Mental Health Act	Care Quality Commission
Disciplinary procedures	Employer
Breach of professional codes of conduct	Professional regulatory body
Breach of Health and Safety Legislation	Health & Safety Executive or Environmental Health http://www.hse.gov.uk/aboutus/howwework/framework/mou/mou-cqc-hse-la.pdf
Breach of contract to provide care	Service commissioners
Scams	Action Fraud www.actionfraud.police.uk
Misuse of lasting power of attorney	Office of Public Guardian https://www.gov.uk/government/organisations/office-of-the-public-guardian
Misuse of appointeeship/benefits/pensions	Department of Work & Pensions https://www.gov.uk/government/organisations/department-for-work-pensions
Inappropriate decisions about care/wellbeing of an adult without mental capacity	Court of Protection https://www.gov.uk/courts-tribunals/court-of-protection
Assessment of need for health and social care provision	Councils with social service responsibilities
Safeguarding Children	Safeguarding Children Services www.liverpoolscb.org/

14.17 Closure of case

It is essential that cases are closed formally and that all of the different elements of the case have been concluded. There are specific tasks that the social worker leading the enquiry should complete at the end of the case:

Ensure that:

- **discussion** takes place with the adult in relation to their desired outcome/s
- **ensure** safeguarding plans are complete and all those involved in the safeguarding plans understand their roles and responsibilities including responsibility for implementing action, raising any concerns, compliance with timescales and responsibility for monitoring and reviewing
- **case** is closed on Liquidlogic, ensuring that the outcome/s and the date the person was made safe is recorded
- **all** parties involved in safeguarding enquiry /networking are informed that the case is completed and closed.

14.18 Informing others that the enquiry is closed

Consideration must be given to who and how those involved in the enquiry are informed of the outcome, any recommendations, safeguarding plans and closure of the enquiry. Depending on the unique set of circumstances you need to consider what the most appropriate method of communication is for each person/organisation which may include:

- a closure letter
- a telephone conversation
- a face-to-face meeting
- a multi-agency meeting – this would not necessarily require the same arrangements as a strategy meeting.

This should be done case by case and agreed with the line manager and recorded on the enquiry outcome report/safeguarding plan.

NB - if another organisation is undertaking the enquiry, the case is not closed until your team has received an outcome and it is closed on Liquidlogic.

15. Strategy meeting

Purpose of the strategy meeting(s)

A strategy meeting is an inter-agency forum to plan the process of the enquiry and any subsequent protection planning. This is a meeting of professionals to examine the information and evidence presented by the various agencies. This is a decision making forum in relation to the most appropriate way forward with the enquiry.

This is the forum to:

- assess the risk to individuals or groups
- decide if an enquiry will be conducted
- establish roles and responsibilities within the enquiry
- decide which organisation will take the lead in the enquiry
- develop safeguarding plans.

15.1 The meeting will not provide any of the following:

Guidance on the initial stages of the enquiry process. This should have been done in conjunction with your line manager. Outcomes - the meeting is not a tribunal to apportion blame. The enquiry should determine the outcomes, conclusion and the finding(s) shared through the appropriate channels

15.2 Timescale for strategy meeting

If the networking process indicates that a strategy meeting is required, then it should be called within five working days of the initial alert. Reconvened strategy meetings are to be called within seven working days. The reason for a longer timescale should be agreed and recorded at the initial meeting.

15.3 Calling a strategy meeting

Following the network process there may be indicators to suggest that a strategy meeting is required, this may include but is not exclusive to:

- serious complex cases
- multi-agency involvement with an individual
- several agencies have concerns and the sharing and pooling of information is desirable
- several individuals are or could be at risk
- there are indications that a number of safeguarding enquiries are being undertaken (or could be)
- the seriousness of the incident.

If following the networking process your manager agrees that a strategy meeting is required, the manager/team leader will contact the locality manager to discuss. The locality manager will need to know the outcome of the networking process, the adult's views and wishes if known, the purpose of the strategy meeting and who needs to attend the meeting. If the locality manager agrees with the rationale for holding a strategy meeting you must contact business support.

Strategy meetings are held on the same day and at the same location each week. The social worker allocated to the safeguarding enquiry needs to give a list of those who should be invited to the diary secretary and the invitations will be made.

15.4 Attendance at strategy meetings

Attendance at strategy meetings is mandatory. The question of who should attend strategy meetings will depend on the nature of the allegation and who the alleged perpetrator is. It is good practice to include the adult and or their representative wherever possible. The manager and social worker responsible for the safeguarding enquiry will need to decide this on the basis of the information received from the networking process.

15.5 Inviting provider agencies / commissioners

Thought must be given to the appropriateness of inviting provider agencies to strategy meetings. It may not be appropriate to invite provider agencies to strategy meetings if the organisation is implicated in any way with the issues of concern. Commissioners of service may need to be invited to the meeting.

15.6 Role of the chair

The chair of the strategy meeting has a number of significant roles to play in ensuring the aims and objectives of the meeting are met.

Before the meeting:

- familiarise themselves with the information
- consider the need for a confidential slot
- brief the minute taker of any difficult areas that may arise.

During the meeting, the chair should ensure the following:

- feedback information from previous related meetings
- agenda is available
- explain the purpose of the meeting and the remit the meeting is conducted under
- the confidentiality agreement has been stated

- go through risk assessments and any reports
- keep meeting focused and on track
- that a safeguarding plan is formulated
- ensure wishes and feelings and outcomes which the adult wishes to achieve are integral to the enquiry
- ensure all attendees are able to have a say
- ensure the minute taker understands what is being said and is noting action points as appropriate.

15.7 Conflicts and disagreements

Safeguarding is a collaborative process and agreement is normally reached through effective communication and open dialogue between organisations. If conflict or disagreement does occur this needs to be recorded in the minutes. Decisions should not be made by a voting process. The chair may need to consider legal advice when reaching decision. In the event that a consensus cannot be reached the chair will make a decision on the evidence presented, giving a clear rationale for the decision which will be documented. Decision making must be measured against information and evidence presented the legal framework and the duty of care.

15.8 Agenda for strategy meetings

An agenda for issues to be discussed at the strategy meeting can be found in the appendices of this document. (See appendix K agenda for strategy meetings.)

15.9 Record of strategy meeting

The strategy meetings will be recorded and minutes will be sent out to participants within ten working days.

16. Adult safeguarding plans

As part of the safeguarding enquiry you may need to develop an adult safeguarding plan to formalise and coordinate the range of action to protect the adult, and to support the adult to recover from the experience of abuse or neglect.

The plan should outline the roles and responsibilities of all individuals and agencies involved, and should identify who will monitor and review the plan, and when this will happen. This should be recorded on the adult's safeguarding plan. (See appendix M adult safeguarding plan.)

Safeguarding plans should be person-centred and outcome-focused. The safeguarding plan should be made with the full participation of the adult, or their representative or advocate as appropriate. Wherever possible, the safeguarding plans should be designed to reflect and aim to achieve the adult's desired outcomes.

The safeguarding plans should not be risk averse. Plans should reflect a positive risk taking approach and be clear how the plan will promote the wellbeing of the adult.

Timescales for monitoring and review of the plan should be set individually when formulating the plan, and should reflect the circumstances and level of risk involved.

If the adult has the capacity to make decisions in this area of their life and declines assistance, this can limit the intervention that organisations can make. The focus should therefore be on harm reduction. It should not however limit the action that may be required to protect others who are at risk of harm. If the person lacks capacity to make decisions in this area then decision made must be in the person's best interest.

There will be occasions where the desired outcomes of the adult cannot be met or where doing so would cause unacceptable risk of harm to the adult or others. Adult safeguarding plans will need to balance the duty of care to safeguard the adult with their right to self-determination. In cases where the adult is not able to understand and make safe decisions, the adult safeguarding plan may need to include restrictions on the adult's choices and lifestyle. Any support or decision that is designed to restrict unsafe choices or behaviour needs to be lawful, proportionate, and least restrictive.

16.1 Positive Risk Management

Risk is the probability that an event will occur with beneficial or harmful outcomes for a particular person or others with whom they come into contact.

Positive risk taking is a process which starts with the identification of potential benefit or harm. The desired outcome is to encourage and support people in positive risk taking to achieve personal change or growth.

Positive risk management does not mean trying to eliminate risk. It means managing risks to maximise people's choice and control over their lives. Positive risk taking recognises that in addition to potentially negative characteristics, risk taking can have positive benefits for individuals, enabling them to do things which most people take for granted. In the right circumstances, risk can be beneficial, balancing necessary levels of protection with preserving reasonable levels of choice and control. A balance has to be achieved between the wishes of adult at risk of abuse or neglect, and the common law duty of care.

16.2 Risk management and personalising choice and control

The goal is to manage risks in ways which improve the quality of life of the person, to promote their independence or to stop these deteriorating if possible. Not all risks can be managed or mitigated but some can be predicted.

Risk management entails broad range of responses and may involve preventative, responsive and supportive measures to reduce the potential negative consequences of risk, and to promote the potential benefits of taking agreed risks. These will occasionally involve more restrictive measures and crisis responses where the identified risks have an increased potential for harmful outcomes

16.3 Interface between adult safeguarding plans and care and support plans.

An adult safeguarding plan is not a care and support plan, it will focus on care provision only in relation to the aspects that provide protection against abuse or neglect, or which offer a therapeutic or recovery based resolution. In many cases the provision of care and support may be important in addressing the risk of abuse or neglect, but where this is the intention the adult safeguarding plan must be specific as to how this intervention will achieve this outcome.

16.4 What sort of actions should be included in adult safeguarding plans?

Adult safeguarding plans can cover a wide range of interventions and should be as innovative as is helpful for the adult. The adult safeguarding plan should include, relevant to the individual situation:

- positive actions to promote the safety and wellbeing of an adult, and for resolution and relevant to the individual situation

- positive actions to promote the safety and wellbeing of an adult, and for resolution and recovery from the experience of abuse or neglect and,

- positive actions to prevent further abuse or neglect by a person or an organisation.

The safeguarding plan should also include consideration of what triggers or circumstances would indicate increasing levels of risk of abuse or neglect for individual/s, and how this should be dealt with (e.g. who to contact or how to escalate concerns).

16.5 Monitoring and reviewing the safeguarding plan.

The social worker should monitor the plan on an ongoing basis, and lead review processes within the timescales agreed on the plan. The purpose of the review process is to:

- evaluate the effectiveness of the adult safeguarding plan
- evaluate whether the plan is meeting/achieving the adult's outcomes
- evaluate levels of current and ongoing risk.

The adult safeguarding plan will no longer be required when the adult is no longer at risk of abuse or neglect, or risks have reduced to the level that they can adequately and appropriately be managed or monitored through single agency processes, e.g. assessment and support planning processes, community policing responses, health service monitoring.

17. Record keeping in adult safeguarding

The importance of good record keeping is essential for all organisations. Accurate records are vital to ensuring the accountability of organisations. If challenged it is essential to be able to demonstrate that decisions were made lawfully. All records are legal documents and can be admissible in civil, criminal and coroner's courts.

Record keeping is an integral part of professional practice and should assist the process. It is not separate from the process and not an optional extra to be fitted in if time and circumstances allow.

When abuse or neglect is raised managers need to look at past concerns, risks and patterns.

17.1 Key question

Are your written records good enough to trigger your memory about why you made a decision or took a specific action?

If the answer is no – then just writing down an action may not be enough. The content of the record needs to be written in a way that means it can act as an aide-memoire maybe many years later.

A record should explain what you did and why you did it. When decisions are made, the reason for making a decision should be explained[2]

17.2 What to record

It is essential to demonstrate how an assessment of risk, responsibility, rights, autonomy and protection of a person was undertaken. All records should include the following:

- all entries must provide factual information, for example, times, dates, names of people present at meetings
- all contact, either face-to-face or by telephone, with the person, carers, alleged abuser must be recorded
- initial discussions with manager on receipt of referral must be logged
- all network discussions with other professional agencies must be recorded
- all discussion with the adult regarding their wishes the outcomes must be recorded and updated as necessary. (The local authority is required to complete statistical returns in relation to discussion with the adult or

[2] Pritchard, J with Leslie, S. 2011. Recording Skills in Safeguarding Adults. London: Jessica Kingsley Publishers, p24

their representative or advocate regarding the adults desired outcomes and if they were met)

- all decisions made, actions taken and the responsibility for carrying out decisions must be recorded on the chronology sheet
- when differences of opinion occur in relation to possible harm/abuse to an adult, a recorded discussion must take place between the persons holding the different views
- records must be clear, accurate and contemporaneous
- each organisation must be able to provide a chronology of actions taken
- all interviews must be written contemporaneously on the statement sheet/s. (See Appendix L statement sheet.)

17.3 Documentation which must be kept on file:

- the referral
- the chronology sheet
- any rough notes must be kept
- any letters or email correspondence
- any documents which constitute supporting evidence
- records of strategy meeting minutes
- assessments of mental capacity and best interests decisions
- witness statements
- risk assessments
- safeguarding plan
- safeguarding enquiry outcome report.

17.4 Service user as perpetrator

If the alleged perpetrator is a service user then information about his/her involvement in a safeguarding enquiry, including the outcome of the enquiry, should be included on his/her case records.

REMEMBER: If it has not been documented it has not been done!

18. Referring a domestic abuse case for a Multi-Agency Risk Assessment Conference (MARAC)

Where the adult experiencing domestic abuse is an adult with needs for care and support and due to those needs is unable to protect themselves a safeguarding concern should be raised under the adult safeguarding procedures. (See Section10.)

Agencies should also complete the Merseyside Risk Indicator Toolkit (MeRIT) following a disclosure of domestic violence (abuse) please see Appendix I. This will provide an assessment on the level of risk and following the guidance included with the MeRIT form, relevant referrals can be made including (if needed) a referral to Multi Agency Risk Assessment Conference (MARAC) see 6.3 page 29.

If the victim is high risk a referral should be made to the MARAC (see chart below). This can be done with the consent of the victim but for those cases were consent is refused agencies will need to consider if the referral should continue. High risk victims can be referred to MARAC without the consent of the victim.

Support to complete the risk assessment or referral to MARAC can be obtained from Safer and Stronger Communities MARAC Officers 233 7016 or MARAC GCSX mailbox.

When referring high risk victims to MARAC, all referrals should also be sent to the Independent Domestic Advisor Service who will advocate on behalf of the victim as part of the MARAC process.

N.B. If the risk score on the MeRIT Risk Assessment does not warrant referral and you believe that the victim is at high risk of further abuse, you may refer to MARAC on ‘professional judgement’.

MARAC Contact: marac@liverpool.gcsx.gov.uk

Liverpool MARAC Combined Operating & Information Sharing Protocol 2015 – 2016:

Available from: marac@liverpool.gcsx.gov.uk

18.1 Immediate danger

Consider any immediate danger to you or person and if in doubt dial 999

18.2 Merseyside Police response

- the duty of the officer is to ensure both the safety of victims, and witness
- if injuries have occurred ensure that the victim receives medical attention if appropriate
- the police officer will ensure that each party is spoken to separately in a place where the suspect cannot overhear, allowing the victim to speak freely
- explain the investigation process and procedures to victim and or/witness and make it clear that the police take these matters seriously
- provide the victim with details of specialist agencies who provide help and information for people suffering domestic abuse
- provide information of the local availability of refuges, victim support, outreach services and a place of safety.

18.3 Initial referrals

The initial referral is passed on to a specialist unit dealing with domestic violence:

Merseyside Police
0151 777 4815 / 4880 / 4866 / 7076

18.4 Domestic violence (abuse) local support services

A list of agencies that can provide information for the person subjected to domestic violence can be found in Appendix S of this document. Agencies can be approached in order to gain information and support.

18.5 Merseyside Risk Indicator Toolkit (MeRIT)

This is the agreed risk assessment used in Liverpool which will enable you to identify the severity of the risk for victims of domestic violence (abuse).

18.6 Liverpool Multi-Agency Risk Assessment Conference (MARAC)

Part 1 – Identifying a case

RISK INDICATOR MeRIT (Merseyside Risk Indicator Toolkit)

Victim identified as high or very high risk – this will also include police call outs, significant concerns and agency concerns. Use risk indicator and guidance on intervention tools.

CONSENT FOR INFORMATION SHARING

Agency worker

- Explains process to victim and receives consent to share information
- Consent is recorded on agency's case file and also on referral form with details of when and how consent was obtained
- Does not receive consent from victim but agency decides that a referral is needed
- Agency worker completes 'information sharing without consent' form and consults guidance document – copy of form is kept on agency's file and the box to share information without consent ticked on referral form and brief details as to why the information is being shared

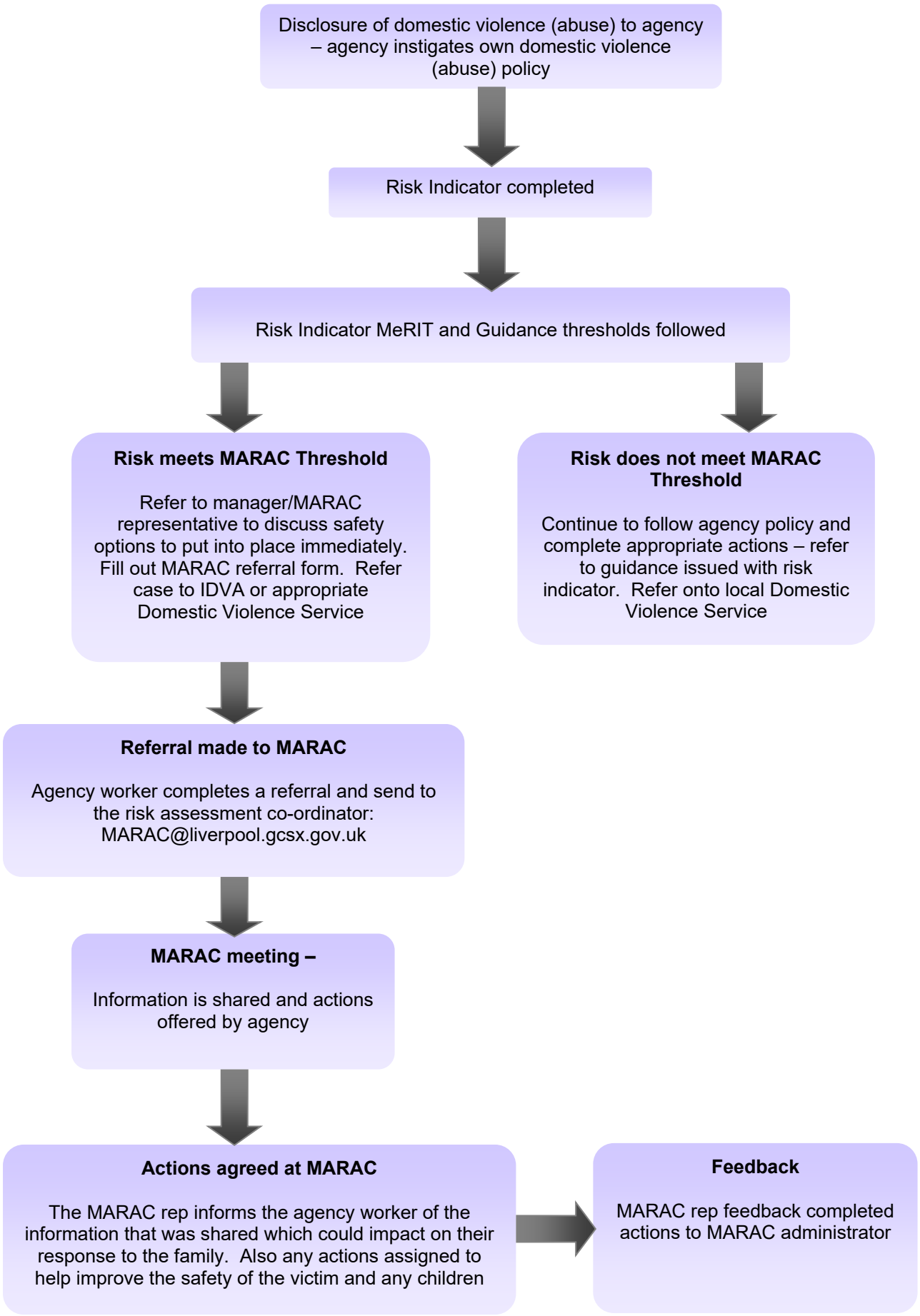
REFERRAL FORM COMPLETED

Agency completes MARAC referral form including relevant information, level of risk and whether or not the person has consent to the referral.

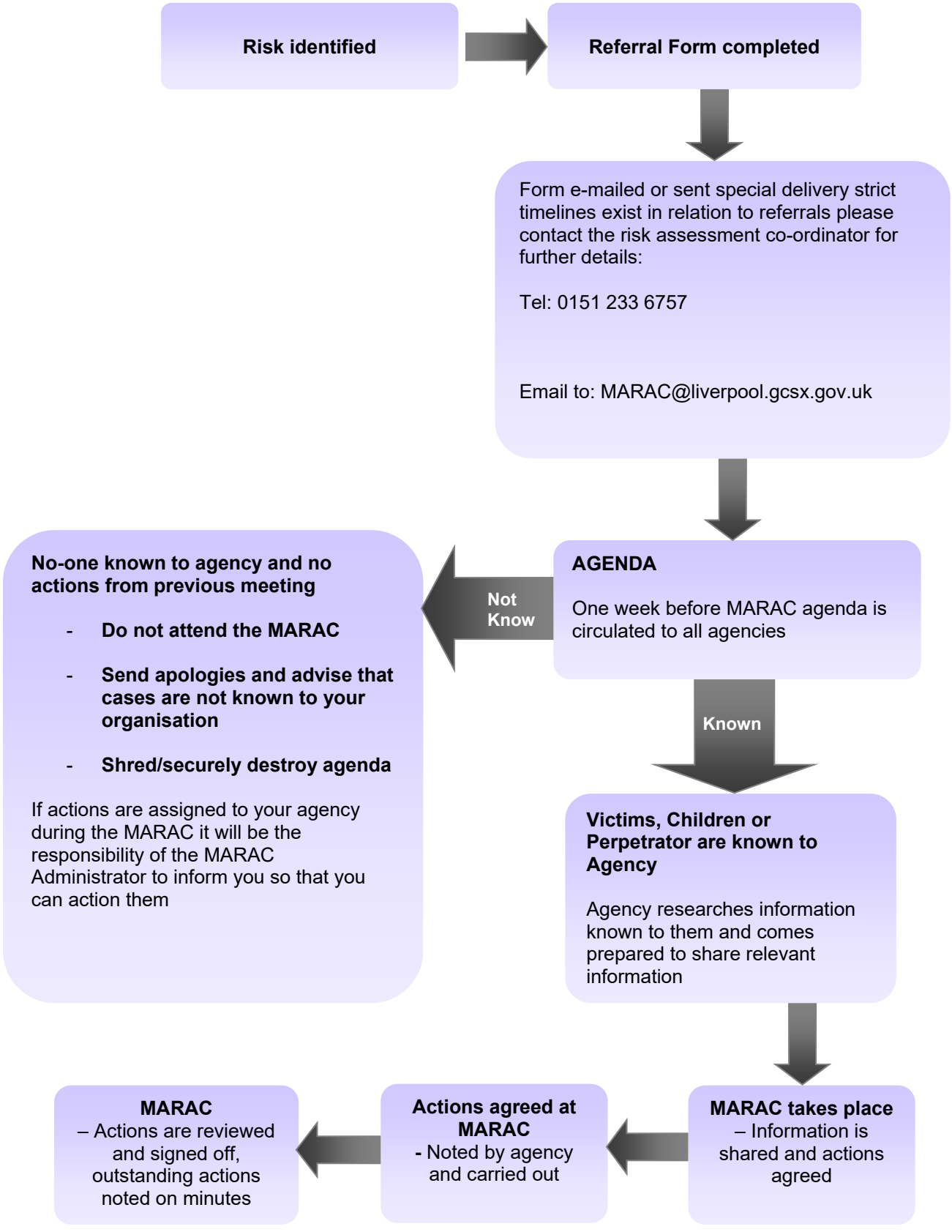
All details should be checked on the MARAC referral from **by the referring agency**

including dates of birth, addresses etc.

Part 2 – Referral process



Part 3 – MARAC process



19. Safeguarding adults reviews – how to make a referral

In line with Section 44 of the Care Act 2014 the Safeguarding Adults Board (SAB) must arrange a safeguarding adults review (SAR) when an adult with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

- there is reasonable cause for concern about how the safeguarding adults board, members of it or other persons with relevant functions worked together to safeguard the adult, and
- the adult has died and
- the safeguarding adults board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)
- the adult is still alive and the safeguarding adults board knows or suspects that the adult has experienced serious abuse or neglect.

In the context of SARS, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

19.1 The purpose of a safeguarding adults review

The purpose of the safeguarding adults review is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

19.2 Initiating a safeguarding adults review

Any agency or professional may refer a case to the Safeguarding Adults Board. If the case meets the criteria above agencies have a duty to make a referral. Referrals must be in writing to ensure the efficient identification of appropriate cases for the Board to consider.

Referrals can be emailed to: SAR@liverpool.gcsx.gov.uk

Or posted to:

Careline Adult Services
Liverpool City Council
Municipal Buildings
Dale Street
L2 2DH
Telephone: 0151 233 3800

Part 3 Appendices

Appendix A The legal framework

The following legal section has been designed to illustrate the numerous and varied pieces of legislation relevant to working with adults. It aims to highlight how the different areas of law are relevant to adult protection.

The general overview provided here must not be used as a substitute for seeking specific legal advice in individual cases.

All of the following will need to be filtered through the Human Rights Act 1998 which came into force in October 2000.

1 Legislation underpinning the service

1.1 The Care Act 2014

This Act is the first statutory framework for safeguarding adults of risk of abuse or neglect. The Act requires that each local authority must:

- make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom
- set up a Safeguarding Adults Board (SAB)
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them
- co-operate with each of its relevant partners (as set out in Section 6 of the Care Act) in order to protect the adult. In turn each relevant partner must also co-operate with the local authority.

1.2 Local Authority Social Services Act 1970

This Act required major reform to the way local authorities discharged their social care responsibilities. It led to the creation of social services departments, to the appointment of directors, to the duty to ensure adequate staff to assist the director and set out the broad framework as to how departments are organised. As a consequence of Local Government Act 2000, social service departments have considerable flexibility as to how their elected members supervise and discharge their functions. This is supported

by Department of Health policy guidance and directions, in respect of the delivery of services to the public.

1.3 Health and Social Care Act 2012

In providing for new structures and means of commissioning and providing health services, the Act makes changes to a number of existing Acts, most notably the National Assistance Act 2006 (the NHS Act) and the Local Government and Public Involvement in Health Act 2007. Much of the wording of the Act is couched in terms of amendments to previous legislation.

Public Health

The transfer of responsibility for public health from the NHS to local government is accompanied by news powers for local authorities both to commission and to provide public health services (Section 1). Public health and health improvement will, therefore, be one of the local government's major functions.

At the local level, the Act gives local authorities the responsibility for improving the health of their local populations. The Act says that local authorities must employ a director of public health.

1.4 National Assistance Act 1948

Section 21 (1) provides that local authorities have a duty to provide residential accommodation for 'people aged 18 or over 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' and who are ordinarily resident in the area or, in urgent need of residential accommodation.

Section 29 (1) the promotion of the welfare of people with disabilities. Local authorities shall make arrangements for promoting the welfare of persons aged 18 or over who are sensory impaired, who suffer from mental disorder of any description, or who are substantially and permanently disabled by illness, injury, or congenital condition.

Section 29(4) Places a duty on the local authority to maintain a register of disabled persons ordinarily resident in their area, to inform persons to whom Section 29 of the National Assistance Act 1948 relates to the services available to them.

1.5 Chronically Sick and Disabled Person's Act 1970

Section 2 The Local authority has a duty to make arrangements for the provision of a variety of services set out in this section to disabled persons who are ordinarily resident in their area. This therefore applies to both adults and children. The services include practical assistance within their home, the provision of recreational facilities, meals and adaptations to the home.

1.6 Health Service and Public Health Act 1968

Section 45 This section empowers the local authority to make arrangements for promoting the welfare of older people. Its aim as far as possible is 'to prevent or postpone personal or social deterioration or breakdown'.

1.7 Housing Act 1996

This Act made a number of major changes to the provision of public and private rented accommodation.

The local authority has a temporary but renewable duty to house certain applicants including homeless people, those in priority need and those unable to access suitable accommodation.

The Act defines a homeless person as one who has no accommodation available to him/her and a person threatened with homelessness, if it is likely to arise within 28 days.

Homeless people are in 'priority need' if they fulfil the criteria listed in the 1996 Act or in the Homelessness 2002 Act.

Part VII of the Act places a duty on the local authority to provide accommodation for homeless people with a 'priority need', that is, 'people who are vulnerable due to old age mental illness, physical disability or other special reason'

1.8 The Homelessness Act 2002

Section 1(2) of the Act requires social services authorities to assist housing authorities in the formulation of their homelessness strategies. The obligation is explained in the Homelessness Code of Guidance 2006 which provides for the social services and housing authorities to co-operate in respect of the strategy. It also provides guidance in relation to specific classes of vulnerable persons including the aged and those with a mental illness, learning or physical disability.

Domestic Violence

The Housing Act 1996 broadened the definition of homelessness for persons experiencing domestic violence from just those living in the home, to an 'associated person'. An 'associated person' is defined under the Code of Guidance to the Acts (and it is the same under part IV of the Family Law Act 1996) as 'people who are or have been married, engaged or living together in the same household, relatives; or people who are parents of a child under 18 or have shared parental responsibility for such a child.'

The 2002 Act was extended to include victims of actual or threatened violence and is not confined to violence in a family or 'domestic' context.

Sections 145 & 149 of the Act provides for the grant of a possession order on the application of the local authority/housing association where a partner has left the dwelling house because of violence or threats of violence by the partner and the court is satisfied that the partner who has left is unlikely to return. A tenancy granted by a private landlord does not qualify.

1.9 National Health Service Act 1977

Schedule 8 Places a duty of care on local authorities to make arrangements to prevent illness, for the care and aftercare of people who are suffering from illness, to provide care to expectant or nursing mothers (other than the provision of residential accommodation) and for home help and laundry facilities.

1.10 Disabled Persons (Service Consultation and Representation) Act 1986

Imposes a duty on local authorities to decide whether the needs of a disabled person; call for provision by the local authority of any services in accordance with Section 2(1) of the CSDPA 1970.

It also provides for the entitlement of disabled people to a written assessment of need and to the right of the disabled person to have a representative present at the time of their assessment.

1.11 Public Health Act 1936 as amended by the Public Health Act 1961

Sections 83-85 Provides the local authority with the power to serve a notice on an owner or occupier of a filthy or verminous premises or to enter and cleanse premises, if the person fails to do so.

1.12 National Health Service & Community Care Act 1990

Section 47 provides a framework for community care assessments for vulnerable adults.

Section 47(1) places a duty on local authorities to carry out an assessment of an individual's needs for community care services. It arises when an individual's circumstances come to the knowledge of the local authority. The duty to assess is central to all community care law. It provides provision for multi-agency involvement for the assessment of complex situations. The lead agency for the co-ordination of assessments is the Social Services Department, with which the responsibility to assess lies.

Section 48 This Section authorises persons to enter and inspect premises in which community care services are proposed to be provided by the local authority. The adult/resident may be interviewed in private for the purpose of investigating a complaint.

1.13 Mental Health Act 1983

The Mental Health Act 1983(as amended by the MHA 2007) is a complex piece of legislation and the following 'guide' should only be used as an index.

The Act governs the reception, care and treatment of mentally disordered patients, the management of their property and related matters.

Section 1 defines mental disorder as "any disorder or disability of the mind". A person with a learning disability can come within the definition if their disability is associated with abnormally aggressive or seriously irresponsible conduct.

Section 2 provides for compulsory admission for assessment in the interest of the person's own health and safety or with a view to the protection of others for up to 28 days. The application is founded on an Approved Mental Health Professional (AMHP) assessment and two medical recommendations.

Section 3 provides for compulsory admission for treatment on the basis that treatment is appropriate, is necessary for the health and safety of the patient or for the protection of others and that appropriate treatment is available. The application is founded on an AMHP assessment and two medical recommendations. Detention is for up to six months, can be renewed for a further six months and then at yearly intervals.

Section 4 provides for emergency admission in cases of urgent necessity for assessment. It requires only one medical recommendation. The application expires after 72 hours. Within the detention period of up to 72 hours, an appropriate second doctor should assess the patient, as soon as possible, to decide whether further detention in hospital is required.

Section 5 provides for the compulsory admission of a patient who is already receiving treatment for a mental disorder in hospital. The application can be made by a single medical practitioner or by a certain prescribed class of nurse. The detention is for up to 72 hours.

Section 7 – 10 provides for the reception of a person over 16 into guardianship. The patient has to be suffering from a mental disorder and the reception into guardianship has to be necessary and in the interest of the person's welfare that they are received. The guardianship is for an initial period of 6 months and is capable of renewal. It can contain a power to compel the patient to reside at a particular place, to attend places for purposes of medical treatment (no power to enforce), occupation, education or training and to require access to the patient. The use of guardianship is intended for people who do not require treatment in hospital but require supervision in the community.

Section 13 places a duty on social services to direct an Approved Mental Health Professional (AMHP) to consider making an application for admission

to hospital or reception into guardianship under the Act. The AMHP can act on a request by a patient's nearest relative.

Section 17(A) (inserted by the 2007 Act) provides for a patient who has been detained under section 3 to be discharged into the community subject to a community treatment order. The application by the doctor cannot proceed unless an AMHP agrees that the order should be made. The order specifies certain conditions that the patient has to comply with in the community, and its purpose is to ensure that he/she receives medical treatment, preventing risk of harm to his/her health or safety and to protect others.

Section 115 If a mentally ill person is not receiving proper care, this section allows an AMHP to enter and inspect any premises where that person is living. Entry by force is not permitted and there is no power to remove the person.

Section 117 places a duty on the local authority jointly with the clinical commissioning group to provide after-care services for persons detained under section 3, persons admitted to hospital in pursuance of a hospital order, under section 37 (by order of the criminal court), under section 45A a hospital direction, under section 47 or 48 a transfer direction with or with a restriction order.

Section 127(1) provides that is an offence for any member of staff of a hospital or mental nursing home to ill-treat or to wilfully neglect a patient, whether an in-patient or an out-patient.

Section 127(2) provides that it is an offence for any individual to ill-treat or to wilfully neglect a mentally disordered person 'in their care or custody'. This therefore could include social workers, care workers teachers, relatives and friends.

Section 129(1) A person will be guilty of an offence if he/she disrupts an AMHP's interview with a patient or obstructs a social worker without reasonable cause.

Section 130 A local social services authority may bring proceedings in relation to an offence under this part of the Act.

Section 135(1) An AMHP can make an application to a Magistrate for a warrant authorising a police officer to enter, if necessary by force, any premises specified in the warrant if he/she believes that a person with a mental disorder is being ill-treated, neglected or otherwise being kept under proper control or, if living alone is unable to care for themselves. The patient may be moved to place of safety for up to 72 hours with a view to making an application for detention under the Act.

Section 135(2) allows a police officer on production of a warrant to enter premises to take or retake a patient who is liable to be detained under the Act. This applies where entry has been refused.

An officer or AMHP may move the person to another place of safety within the 72 hours.

Section 136 provides a Police officer with the power to remove from a public place to a place of safety, a person who appears to be suffering from a mental disorder if the officer thinks it is necessary in the interests of that person or for the protection of other persons. The person may be detained for up to 72 hours and an officer or AMHP may move the person to another place of safety within that time frame.

Section 130A- D Independent Mental Health Advocate (IMHA)

The Mental Health Act 2007 makes provision for independent mental health advocates to be available to support qualifying patients. The IMHA will assist patients to understand their rights, obtain information and support patients to get their views across.

Qualifying patients:

- any patient who is detained in hospital under the Mental Health Act (apart from those kept under short term holding powers and emergency sections)
- any patient subject to a Guardianship Order under the Act
- any patient on a Supervised Community Treatment Order (SCT)
- any informal patient and under 18 years of age who are being considered for more serious medical treatment
- any patient who is conditionally discharged.

1.14 Mental Capacity Act 2005 (MCA)

The Mental Capacity Act 2005 provides a statutory framework for making decisions in the best interest of individuals who lack the mental capacity to make decisions for themselves. The Act came into force in October 2007.

The Government added a new provision to the Mental Capacity Act 2005, The Deprivation of Liberty Safeguards. The Safeguards have been created to ensure that any decision to deprive someone of their liberty is made following defined processes. (See section 6.6 deprivation of liberty safeguards.)

Independent Mental Capacity Advocates (IMCAs)

The Mental Capacity Act 2005 makes provision for the appointment of Independent Mental Capacity Advocates to represent and support a person who lacks capacity to make decisions when certain acts or decisions are proposed.

The decision **must** be about:

- serious medical treatment

- an NHS body proposal to make provision/ change accommodation in a hospital or care home
- a local authority proposal to make provision for / change residential accommodation
- a person subject to DOLS
- safeguarding issues
- the person has no relatives or friends to speak up for them; however this does not apply in relation to safeguarding issues.

Financial Protection

The Mental Capacity Act 2005 replaced the previous arrangements for managing the financial affairs of persons unable to do so themselves.

Lasting Power of Attorney

The MCA allows for the creation of a Lasting Power of Attorney (LPA)by which an 'attorney' is appointed to make property and financial decisions on a person's behalf when the person no longer wishes to, or loses the capacity to do so themselves. An LPA cannot be used until it has been registered with the Office of the Public Guardian**.**

Deputyship

In situations where a person has lost capacity to manage their own financial affairs but has not appointed an Attorney and there is no family member to take on the role, then the local authority can apply to the Court of Protection to be appointed as a Deputy to manage the person's property and affairs. A Declaration of Incapacity must accompany an application to the Court. This procedure is also available where there are safeguarding issues regarding a person's finances.

Enduring Power of Attorney

If there is in existence an Enduring Power of Attorney made before 1 October 2007, it can still be used, and the Attorney will still need to register it with the Office of the Public Guardian if a person in respect of whom the EPA has been made, is becoming mentally incapable.

Department of Works and Pensions

Agency The claimant nominates someone to collect his/her benefit on their behalf. This is based on an understanding between the claimant and the agent.

Appointeeship If a person does not have the mental capacity to manage their benefits, the Department of Work and Pensions (DWP) can nominate someone to collect that person's benefits.

2. Administrative Law

2.1 Data Protection Act 1998

This Act repeals the Data Protection Act 1984. It also repeals the Access to Personal Files Act 1987 and most of the Access to Health Records Act 1990. This Act applies to anyone processing personal data.

2.2 Freedom of Information Act 2000

The Act establishes a general right of access to all types of information held by public authorities.

3. Criminal Law

3.1 Police and Criminal Evidence Act 1984

Provides the police with powers of entry, arrest, search, seizure of evidence and the treatment of persons detained by the police.

Section 24 (as amended by the Serious Organised Crime and Police Act 2005) a lawful arrest requires a person's involvement, suspected involvement or attempted involvement in the commission of a criminal offence and reasonable grounds for believing that the person's arrest is necessary.

Section 25 Allows the Police to arrest someone to prevent them causing physical injury to another person or to protect a child or others.

3.2 Criminal Justice Act 1988

Section 39 – Common Assault

Assault is defined as any physical contact without consent. Includes acts of words involving threat of violence; no physical evidence may be present; assault and battery-which involves the threat of immediate violence.

3.3 Offences Against the Person Act 1861

Assault which leaves a physical injury (any age).

Section 18 - grievous bodily harm or wounding with intent to commit grievous bodily harm includes assault causing cuts, broken bones and damage to internal organs.

Section 20 - Grievous Bodily Harm without intent.

Section 38 - Assault with intent to resist apprehension.

Section 47 - Assault occasioning actual bodily harm. This includes temporary loss of sensory functions, which may include loss of consciousness, extensive or multiple bruising, displaced broken nose, minor fractures, minor but not merely superficial, cuts of a sort probably requiring medical treatment (e.g. stitches), psychiatric injury that is more than merely emotions such as fear, distress or panic.

3.4 Equality Act 2010

Covers racially inspired offences.

3.5 Crime and Disorder Act 1998 – Part II

Racially Aggravated Offence: England and Wales

Section 28 (1) An offence is racially aggravated if:

- at the time of committing the offence, or immediately before or after doing so, the offender demonstrates towards the victim of the offence hostility based on the victim's membership (or presumed membership) of a racial group
- the offence is motivated (wholly or partly) by hostility towards members of a racial group based on their membership of that group.

Section 115 Disclosure of Information

(1) Any person who…would not have power to disclose information:

- to a relevant authority, or
- to a person acting on behalf of such an authority, shall have power to do so in any case where disclosure is necessary or expedient for the purpose of any provision of this Act

(2) In subsection (1) above 'relevant authority' means:

- the chief officer of police for a police area in England and Wales
- the chief constable of a police force maintained under the Police (Scotland) Act 1996
- a local authority
- a probation committee in England and Wales
- a health authority.

3.6 Youth Justice and Criminal Evidence Act 1999

Part II Giving Evidence or Information for Purposes of Criminal Proceedings

Sections 16 and 17 and 17(2) Eligible Witness

Witnesses other than the defendant, who already has the benefit of a number of procedural safeguards, will be eligible for special measures to help them with giving evidence in criminal proceedings if:

- they are under 17 years of age
- they suffer from a mental disorder, or have a mental impairment or learning disability, which would include autistic spectrum disorders, that the court considers significant enough to affect the quality of their evidence
- they have a physical disorder or disability, which would include deafness, that the court considers likely to affect the quality of their evidence.

Section 17.2
The court is satisfied that the witness/es are likely, because of their own circumstances and the circumstances relating to the case, to suffer fear or distress in giving evidence to an extent that is expected to affect its quality

It will be possible to make applications, and for courts to grant special measures, on more than one of these grounds.

3.7 Sexual Offences Act 2003

The Act sets out to provide greater protection to the public from dangerous offenders. It provides protection for the most vulnerable by providing clear and effective laws that will better respond to today's type of sexual abuse. It modernises sex offences so that they do not discriminate on the grounds of gender. It will provide penalties that enable appropriate punishments and strengthens the Sex Offenders Register by tightening notification requirements and broadening offences that trigger registration.

3.8 Theft Act 1968

Theft is the dishonest appropriation of property belonging to another, intending to deprive the owner permanently

3.9 Protection from Harassment Act 1997

Section 1 Creates an offence of harassment and fear and violence. For both offences there needs to be evidence that the harassment or threats of violence occurred on more than one occasion. It is intended to provide for conduct falling short of physical assault. The perpetrator can be arrested after an initial warning. At sentencing a restraining order can be applied. Breach of the restraining order is a criminal offence.

3.10 Crime and Security Act 2010

This legislation prevents a suspected perpetrator from entering the address of the victim and/or contacting the victim. A Domestic Violence Protection Notice (DVPN) is issued by the police in order to provide emergency protection to the victim, it includes certain prohibitions and must be heard by a Magistrates Court within 48 hours. The police apply to the courts for a Domestic Violence Protection Order after a DVPN has been issued. Under DVPOs, the perpetrator can be prevented from returning to a residence and from having contact with the victim for up to 28 days.

3.11 Domestic Violence Disclosure Scheme Clare's Law

The Domestic Violence Disclosure Scheme went live nationwide on 08 March 2014, giving members of the public a 'right to ask' Police where they have a concern that their partner may pose a risk to them, or where they are concerned that the partner of a member of their family or friend may pose a risk to that individual. If an application is made under the scheme, police and

partner agencies will carry out checks and if they show that the partner has a record of abusive offences, or there is other information to indicate that there may be a risk from the partner, the Police will consider sharing this information.

3.12 Domestic Violence, Crime & Victims Act 2004 (Amendment) 2012 Section 5 includes the following:

- a new offence introduced, applying to those defendants who cause or allow the death or serious physical harm of a child or vulnerable adult
- defendant must be a member of the same household as the deceased/seriously physically harmed who has had frequent contact with them
- a defendant will be guilty where they cause the death or serious physical harm, or where they were aware, or ought to have been, aware that the deceased/seriously physically harmed was at risk and took no reasonable steps to prevent a death/serious physical harm which was foreseeable
- the new offence may be jointly charged with murder or manslaughter and if jointly charged:
    - the submission of no case to answer is postponed until all evidence has been given
    - the charge of murder or manslaughter may not be dismissed until the charge relating to the new offence has been dismissed
    - adverse influences which may be drawn in relation to the new offence may also be drawn in relation to the charge of murder or manslaughter.

3.13 Corporate Manslaughter Act 2008

The Act introduces a new offence for prosecuting companies and other organisations for gross failure in the management of health and safety with fatal consequences

3.14 The Safeguarding Vulnerable Groups Act 2006 and Protection of Freedoms Act 2012

The Disclosure and Barring Service (DBS) was formed in 2012 under the Protection of Freedoms Act 2012. The DBS enables employers in the public private and voluntary sectors to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults in regulated activity. It is the employer's responsibility to ensure that all DBS checks are undertaken on staff working in regulated activity. It is illegal for anyone barred by the DBS to work with adults from which they are barred. It is also illegal for

an employer to knowingly to employ a barred person in the sector for which they are barred.

If someone is removed from their role providing regulated activity following a safeguarding incident by being either dismissed or redeployed to a non-regulated activity, or they leave their role (resignation or retirement) to avoid a disciplinary hearing, and the employer or volunteer organisation feels they would have dismissed the person based on the information they hold, they have a legal duty to refer to the DBS. If an agency or personnel supplier has provided the person, then the legal duty sits with that agency. In circumstances where the employer does not make a referral then the local authority can make such a referral.

https://www.gov.uk/government/organisations/disclosure-and-barring-service

3.15 Criminal Justice and Court Act 2015

Section 20 makes it an offence for an individual to ill-treat or wilfully neglect another individual of whom he has the care by virtue of being a care worker. A "care worker" is defined as anyone who, as paid work, provides social care for adults or health care for children or adults. The 'wilful' element of the neglect offence connotes that the perpetrator has acted deliberately or recklessly. Similarly, 'ill-treatment' is a deliberate act, where the individual recognised that he was inexcusably ill-treating a person, or else was being reckless as to whether he was doing so. Genuine errors or accidents by an individual would therefore not be caught within the scope of this offence.

Section 20 creates an either way offence which carries a maximum penalty of imprisonment of up to 5 years and/or a fine.

Section 21, provides for a care provider to be guilty of an offence if:

- someone who is part of the care provider's arrangements for the provision of care ill-treats or wilfully neglects an individual under the care provider's care

- the way in which the care provider manages or organises its activities amounts to a gross breach of a relevant duty of care owed by it to the victim; and

- if that breach had not occurred the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.

A 'care provider' is defined as a body corporate or unincorporated association which provides or arranges for the provision of health care (other than excluded health care) or adult social care. A 'care provider' can also include an individual who provides these services and employs/makes arrangements

for other people to assist in providing that care. The care provider offence can therefore be committed by both provider organisation such as hospitals and by partnerships or individuals providing care, for example GP practices.

4. Other Civil Statute

If the evidence available does not meet the criminal standard of proof beyond all reasonable doubt, it may meet the less stringent civil standard of the balance of probabilities. Compensation may be sought from the Criminal Injuries Compensation Board or by suing in civil law for compensation.

Adults should always be advised of the right to discuss mistreatment with the police and/or an independent legal advisor.

In many cases the individual may not be able to give instructions to a lawyer so before the case can proceed someone must be found to act on his/her behalf. He/she may 'sue by a next friend' under Order 10 of the County Court Rules or order 80 of the Supreme Court

4.1 Public Interest Disclosure Act 1998 (Chapter 23)

This Act creates a framework for whistle blowing, or 'qualifying disclosure' by workers across the private, public and voluntary sectors.

Whistle Blowing Procedure

Key aspects of such procedures, as endorsed by the Committee on Standards in Public Life (supra) are:

- a clear statement that malpractice is taken seriously within the organisation
- respect for the confidentiality of staff raising concerns, if they wish it
- the opportunity to raise concerns outside the line management structure
- penalties for making allegations maliciously
- an indication of the proper way in which concerns may be raised outside the organisation if necessary.

4.2 Forced Marriage (Civil Protection) Act 2007

The Forced Marriage (Civil Protection) Act 2007 came into force on 25 November 2008. The aim of the Act is to provide civil remedies for those faced with forced marriage, and victims of forced marriage. Under the Act, victims may apply to the court for a Forced Marriage Protection Order

(FMPO). A relevant third party, such as a local authority, may also apply on behalf of the victim for an FMPO.

A Forced Marriage Protection Order is a civil application but the breach of an FMPO is criminal. Section 120 of the Anti-social Behaviour, Crime and Policing Act 2014 criminalises the breach and that Act amends section 63CA Family Law act 1996.

The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage[3].

This guidance sets out the duties and responsibilities of agencies with the aim of protecting children, young people and adults facing forced marriage.

'As forced marriage is a form of child / adult / domestic abuse, it should form part of existing child and adult protection structures, policies and procedures'.[4]

See link below Liverpool Forced Marriage Protocol
http://www.liverpoolscb.org/files/forced_marriage_protocol.pdf

4.3 Family Law Act 1996

Part IV of the Family Law Act 1996 provides a civil remedy for molestation, violence and occupation of a home.

Section 33 Provides for Occupation Orders to regulate the occupation of a home shared by a couple and their children to protect any party or children from domestic violence. The order can exclude a person from the property or prevent the person from re-entering.

Eligibility to apply is based on association through familial type relationships and entitlement to occupy the family home. These include married/former married persons, civil or former civil partners, cohabitants/ former cohabitants, persons who live or are living in the same household, relatives; persons who have agreed to marry each other or enter into a civil partnership.

The application is made in any court with family jurisdiction and the court may make orders to regulate the occupation of a dwelling house. Since July 2007 section 4 of the Domestic Violence, Crime and Victims Act 2004 extended "associated" persons to include persons who 'have or have had an intimate relationship with each other which is or was of significant duration', but have never married or cohabitated.

A "balance of harm " test is applied to find out which person and/or children living with them will be at most risk if an order is/is not made.

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[3] Part two of the guidance is issued as statutory guidance under section 63Q(1) of the Forced Marriage (Civil Protection) Act 2007

[4] The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage, 18 & 19 page 7

Occupation orders can include a penal notice which states that the person if they do not comply with the Order will be guilty of contempt of court and may be sent to prison. The Court can also attach a Power of Arrest where violence or threat of violence has been found. This enables a police officer to arrest without a warrant someone suspected to be in breach of an order.

Section 42 Provides for the grant of a Non-molestation order which is used to deter someone from causing, or threatening violence to the applicant or to any children or from molesting them.

The class of the potential applicants is extremely wide. In general, if a victim of domestic violence is related to the perpetrator of the violence, this Act can be used as a remedy. An 'associated' person can include: father, mother, son, daughter, step relationships, grandparents/children of a person or of that person's spouse or former partner; siblings, uncle, aunt, niece, nephew, someone who lives or who has lived, in the same household.

Since 1 July 2007, section 1 of the Domestic Violence Act 2004 amends the FLA to make a breach of a non-molestation order a criminal offence and therefore courts are no longer allowed to attach a POA to non-molestation orders.

4.4. The Human Rights Act 1998

This Act came into force in October 2000. From a legal perspective the Act brings into English law a distinct and different approach to thinking about rights, responsibilities and remedies. There are four schedules all of which need to be taken into consideration.

5. Common Law

In situations of urgent high risk and in order to save life, it is acceptable under common law to intervene without consent.

6. Law of Tort

Injunctions may be available for assault, battery, nuisance, false imprisonment and trespass

Appendix B Liverpool's Dignity in Care Charter

This charter is a joint initiative between Liverpool City Council, Liverpool Primary Care Trust, Liverpool Health and Social Care Champions and representatives of the city's service user's and carers.

It will be embedded in the creation of a care system where there is zero tolerance of abuse and disrespect of adults. We are committed to taking a partnership approach in Liverpool to achieve high quality services that respect people's dignity, rights and choices.

This charter underlines what any person can reasonably expect when they access health and social care services in Liverpool.

We will:

Dignity

- respect a person's uniqueness
- provide person centred care
- have zero tolerance of all forms of abuse
- respect people's right to privacy.

Respect

- provide effective communication (involving any specialist requirements)/listening from day 1 to enable successful outcomes and wellbeing for the individual
- consider the person's best interests and ensuring these are at the heart of everything we do
- respect people's home/property/environment
- engage appropriately with family members/carers.

Autonomy

- ensure support services place people at the centre of the decision making processes, including choice control and design of services
- encourage and support people to have the confidence to challenge.

Fulfilment

- support people in making informed choices and decisions to achieve personal goals – sometimes dreams can come true
- foster positive environments which will build relationships to reduce loneliness and isolation.

Staffing

- ensure commissioners and providers are aware of their responsibilities concerning effective recruitment and training processes to provide an appropriately skilled workforce
  involve service users and family/carers in training to share their experiences.

Liverpool Primary Care Trust NHS

Liverpool Health & Social Care Champions

Liverpool Social Care Partnership

Liverpool City Council

Appendix C Responding to incidents between service users

This guidance is for managers of residential and nursing homes, supported tenancies, resource/day centres and transport. Its purpose is to help support managers in deciding whether a safeguarding concern should be raised when an incident occurs between service users.

Every adult at risk of abuse has the right to support and protection within the Liverpool inter-agency safeguarding procedures. Services must ensure that prompt appropriate action is taking to safeguard all service users. When any service user has been harmed during an incident, a safeguarding concern must be reported to Careline on 0151 233 3800.

Abuse as a crime

Alongside the safeguarding procedures, adults must be afforded the same rights to justice and the protection of the law as any other citizen. Where a crime is suspected, it should be reported to the police with the consent of the adult at risk

A crime may also need to be reported without the person's consent, where there is a duty of care to report the crime and/or it is assessed as in the person's best interests in line with the Mental Capacity Act 2005.

Examples of such crimes include:

- being physically assaulted (even if there is no resulting injury) may be an offence under Section 39 of the Criminal Justice Act 1988
- unwanted sexual touching (intentional) may be an offence under Section 3 of the Sexual Offences Act 2003
- harassment (causing alarm or distress) of another person may be an offence under the Protection of Harassment Act 1997
- taking the money or possessions of others may be an offence under Section 1 of the Theft Act 1968.
- ill treatment or wilful neglect: Care workers offence under S20 of the Criminal Justice and Courts Act.

Refer to Liverpool inter-agency safeguarding adults procedures for further guidance and/or contact the police for advice.

When should you raise a safeguarding concern?

In determining whether an incident between service users should be reported under the safeguarding adults procedures it is important to take into consideration the unique circumstances of the situation in reaching your decision. Consideration should be given to:

- the care and support needs of the alleged victim
- capacity of the victim and alleged perpetrator
- balance of power of the victim and alleged perpetrator
- the nature and extent of harm caused
- the frequency of incidents
- impact on the person
- the risk of repeated or increasingly serious acts involving this or other adults
- the risk that serious harm may occur if no action taken
- has a crime been committed
- their views and those of the family/friend/advocate if known.

We recognise that sometimes 'one off' low level incidents do occur between service users. Where no harm has occurred and where it is an isolated incident and the incident has been dealt with promptly by the provider to the satisfaction of the person involved there would be no need to refer the incident under the safeguarding adults procedures.

The examples below can be used as a general guide to support your decision making, however it is important to remember to take into account the unique circumstances of the situation in reaching your decision. If in any doubt you should contact Careline on 0151 233 3800 for further advice.

	Examples where a safeguarding concern may not be required **Consider alternative responses e.g. revised care plans, care reviews, notify the social worker for an unscheduled review/complaints etc.**	**Examples where a safeguarding concern is likely to be required.** **Raising a safeguarding concern means reporting a concern to the safeguarding procedures.**
1.	One service user taps or slaps another but not with sufficient force to cause a mark or bruise and the victim is not intimidated. Isolated incident. Care plans amended to address risk of re-occurrence.	Isolated incident causing harm predictable and preventable (by staff) incident between two service users at risk Harm may include: bruising, abrasions and or emotional distress caused.
2.	One service user is teased or	Isolated incident (s) resulting in harm

	spoken to in a rude, insulting, belittling or other inappropriate way by another service user. Isolated incident. Respect for them and their dignity is not maintained but they are not distressed. Actions being taken to prevent reoccurrence.	or recurring/persistent, or is happening to more than one adult at risk. Persistent teasing Harm may include distress, demoralisation, loss of confidence or dignity.
3.	Isolated incident of teasing or low level unwanted sexualised attention (verbal or non-intimate touching) directed at adult without capacity. Care plans being amended to address incident. Person not distressed or intimated.	Intimate touch between service users without valid consent or recurring verbal sexualised teasing resulting in harm. Harm may include: emotional distress, intimidation, loss of dignity.
4.	Isolated Incident of service user being treated differently/unfairly for reasons of race, sexual orientation or age by another service user. Actions being taken to address incident. Person is not distressed, intimidated or socially excluded. Isolated teasing incident comment reflecting discriminatory beliefs. No distress caused. Appropriate actions being taken to address incident.	Isolated incident resulting in harm, reoccurring or repeated incident. A hate crime or deliberate intent to cause distress. Harm may include: distress social exclusion, social withdrawal, loss of confidence.
5.	Service user has borrowed items or money from another service user with their consent but items/money are not returned to them. Action being taken to address issue and prevent reoccurrence.	Service user has taken item(s) or money from another service user and not returned/repaid them

If in doubt please contact Careline on 0151 233 3800

Responsibilities in relation to the adult at risk

Alongside the decision to report a safeguarding concern under the safeguarding adults procedures you must also:

- assess the risk of harm. Seek medical attention if needed
- assess the person's mental capacity
- take action needed to keep the person safe
- consider if the incident needs reporting to the police
- consider if the person has any unmet needs
- review relevant care plans/risk management plans
- provide help to understand the procedures
- provide support to participate in the safeguarding procedures
- keep clear records of actions and decisions.

Responsibilities in relation to the person alleged to have caused harm

Alongside the decision to report a safeguarding concern under the safeguarding adults procedures, you must also:

- assess the risk of further incidents
- assess the person's mental capacity
- review the person's care/risk management plan
- consider if the person has any unmet needs
- help them to understand the safeguarding procedures
- provide support to participate in the safeguarding procedures
- keep clear records of actions and decisions.

Responsibilities of the organisation/care provider

Alongside the decision to report a safeguarding concern under the safeguarding adult procedures, you must also:

- consider if a crime has occurred and needs to be reported to the police
- identify if an advocate is required
- preserve evidence where a crime has occurred
- notify your regulator e.g. Care Quality Commission
- consider if there are any risks to other service users
- provide any support to the person raising the concern
- keep clear records of actions and decisions
- identify any organisational learning as how to prevent and respond to such incidents in the future
- provide support at staff teams.

Appendix D Liverpool safeguarding adults procedures pressure ulcer guidance

Introduction

This guidance is for all staff in all sectors within Liverpool whether hospital, care home or community setting, who are working with people who develop pressure ulcers that may have been caused by neglect or poor practice. All cases of alleged neglect MUST be referred to adult safeguarding.
There is a link that can exist between the development of significant pressure ulcers and the possible poor practice or neglect in the person's care which needs to be considered under safeguarding adults.

What is a pressure ulcer?

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with a shear force. A number of contributing factors are also associated with pressure ulcers although the significance of these factors is yet to be determined.

International NPUAP- EPUAP Pressure Ulcer Classification System

Grade of pressure ulcer	Presentation
Grade 1 Non-blanchable redness of intact skin	Intact skin with non-blanchable erythema of a localized area usually over a bony prominence. Discoloration of the skin, warmth, edema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching. Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Grade1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons
Grade 2 Partial thickness skin loss or blister	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serumfilled or sero-sanginous filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. This grade should not be used to describe skin tears, tape

	burns, incontinence associated dermatitis, maceration or excoriation
Grade 3 Full thickness skin loss (fat visible), full thickness tissue loss	Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Some slough may be present. May include undermining and tunneling. Further description: The depth of a Grade 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Grade 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Grade 3 pressure ulcers. Bone/tendon is not visible or directly palpable.
Grade 4 Full thickness tissue loss (muscle/bone visible)	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often include undermining and tunneling. Further description: The depth of a Grade 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Grade 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible.

Pressure ulcers can occur in any environment and are generally avoidable. They cause pain and discomfort. When present pressure ulcers require monitoring and appropriate treatment in order to prevent unnecessary pain and suffering for the person concerned.

N.B. Registered healthcare professionals may not always be involved with patients at risk of pressure ulcers. Where a risk is identified a referral to health professionals for advice should be instigated. This can be done via the GP where an individual is not known to the District Nurse Service.

Avoidable pressure ulcer

“Avoidable” means that the person receiving care developed a pressure ulcer and the provider of care did not do one or more of the following:

- evaluate the person's clinical condition and pressure ulcer risk factors; (e.g. no evidence of risk assessments, Waterlow and Malnutrition Universal Screening Tool (MUST)
- plan and implement interventions that are consistent with the person's needs and goals (e.g. no evidence of repositioning, turn charts, patient information and / or leaflet, did not provide appropriate equipment - mattress and seating)
- recognise scope of practice (e.g. no referral to District Nurse (DN) by Care Agency / Tissue Viability Nurse (TVN) by health professionals
- carry out risk assessments
- monitor and evaluate the impact of the interventions (e.g. no monitoring or evaluation of the wounds, equipment, repositioning regime)
- revise the nursing / care interventions as the clinical condition has changed
- carry out prescribed care by a health professional.

Unavoidable pressure ulcer

"Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider:

- evaluated the person's clinical condition and pressure ulcer risk factors (e.g. evidence of risk assessments, Waterlow and MUST)
- planned and implemented interventions consistent with the person's needs and goals (e.g. evidence of repositioning, turn charts, patient information and /or leaflet, provided appropriate equipment - mattress and seating, review of care package
- recognised scope of practice (e.g. timely referral to DN /TVN was made)
- monitored and evaluated the impact of the interventions amending as appropriate
- revised the care / actions as appropriate
- or where the individual has capacity and refused to adhere to prevention strategies, in spite of education of the consequences of non-adherence, there is documented evidence of verbal instructions, appropriate escalation of the concerns, appropriate advice sought (e.g. TVN) and the advice / adherence is revisited by those providing care at appropriate times.

Pressure ulcer prevention and management

It is widely accepted that pressure ulcers are, for the most part, preventable if:

- the circumstances which are likely to result in pressure ulcers are recognised
- those at risk are identified early
- appropriate prevention measures are implemented without delay

Organisations should follow their local and national guidance (National Institute for Clinical Excellence - NICE) on prevention and management of

pressure ulcers.

On admission at the first episode of care a risk assessment using an appropriate tool e.g. Waterlow assessment tool should be performed and results documented in the care records. Any identified care need should be met and clearly documented. Risk assessment should be ongoing and is the responsibility of the registered health care professionals working with that person.

Pressure ulcers and neglect
Pressure ulcers can occur due to neglect whether this is deliberate or by omission of care. Neglect is the deliberate withholding or unintentional failure to provide appropriate and adequate care and support and this has resulted in, or is highly likely to result in, a preventable pressure ulcer.

Not all pressure ulcers in an adult at risk are the result of neglect. Pressure ulcers could also be acquired by people in their own home, possibly due to self- neglect, the individual with capacity choosing to decline support and advice, or in those without the capacity to understand what support is required or the capacity to follow advice given. Where self neglect is apparent a referral should be made to Careline. However consideration must be given as to whether neglect has occurred.

Omission of care or poor practice that has resulted in a person developing a pressure ulcer, therefore suffering harm, must be reported using the safeguarding adults procedures. Professionally registered staff making referrals should give as much detail available to them regarding what is known to have caused the pressure ulcer / omissions of care evident, e.g. no positioning regime, inappropriate equipment, missed visits etc. This will enable Local Authority staff to triage appropriately.

The following are likely indicators of poor practice:

- no assessment or reassessment of risk
- failure to act upon findings of risk assessment
- lack of appropriate equipment
- poorly maintained equipment
- staff not trained in using equipment
- staff not trained in manual handling
- staff not having an awareness of pressure ulcer prevention and management
- nutritional assessments not completed
- repositioning charts not used or not clearly completed
- specialist advice has not been sought
- care plans and records are not clear and concise and up to date
- missed visits by care providers / health providers
- capacity assessments not undertaken where required
- lack of explanation or appropriate engagement by staff.

The person's mental capacity to agree to their care must also be assessed. Records should be kept of the person's compliance with their care plan as well as any best interest decision where the person lacks capacity.

The Care Quality Commission should be notified of any Grade 3 and 4 pressure ulcer along with the completion of your organisation's incident reporting system.

Where a pressure ulcer has developed all organisations providing care must consider whether the possible cause is neglect. Neglect may not be immediately obvious and may be determined during a review of the case. If there is evidence of neglect it requires reporting as an adults safeguarding concern. This includes whether or not the person acquired the pressure ulcer in hospital, care setting or their own home. If you are aware an adults safeguarding concern has already been made prior to admission to hospital / caseload, unless the pressure ulcer has deteriorated further whilst in your care, there may not be a need to raise a further safeguarding concern.

Providers of healthcare will also need to consider whether the development of a pressure ulcer and the effects of the pressure ulcer meet the criteria to report as a Serious Incident see link below:

http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf

Where there is a Root Cause Analysis (RCA) undertaken for a Serious Incident report, that has also been referred as a safeguarding adult concern, the social worker co-ordinating/making the enquiry will liaise with the Clinical Commissioning Group (CCG) in relation to the outcome of the serious incident report.

An investigation using RCA should be carried out as per local policy and recorded on appropriate documentation. Responsibility for conducting a RCA would normally lie with the organisation responsible for the person's care in the setting where the pressure damage developed. Where an adults safeguarding concern has been made and a decision is reached to investigate, the RCA will form part of the investigation. The outcome of the RCA/investigation must be shared with the social worker coordinating the Section 42 enquiry.

Treatment, evaluation, prevention and management of the pressure ulcer should be ongoing regardless of any enquiries being undertaken.

Liverpool City Council

NHS Liverpool Clinical Commissioning Group

Falls in Community Settings of Care

Guidance for responding to falls

Contents page

Appendices:

Definition of a fall

"An unexpected event when a person 'falls' to the ground from any level, this also includes falling on the stairs and onto a piece of furniture with or without loss of consciousness".

National Institute for Clinical Excellence (NICE, 2004)

National picture

Falls and fractures amongst people aged 65 and over account for over four million hospital bed days each year in England alone[1]. The associated healthcare costs are estimated at £2.3 billion per annum, in addition falls resulting in injury are the leading cause of accident related mortality among older people. After a fall, an older person has a 50% chance of having seriously impaired mobility and a 10% chance of dying within a year[2].

People over 65 have the highest risk of falling and 30% of adults who are over 65 and living at home will experience at least one fall a year (approximately 2.5 million people in England). This rises to 50% of adults over 80 who are either at home or residential care, most falls do not result in injury, but annually approximately 5% of older people living in the community who fall, experience a fracture or need hospitalisation[3].

Local picture

Using Department of Health (DH) analysis and Liverpool's registered practice population, it is estimated that:

- 34.4% (24,505 patients) over 65 will fall each year
- 14.8% (10,600) of this population will fall twice or more in a year. Though most will not seek help
- An estimated 4.8% (3,476) will call an ambulance, and the same number will attend accident and emergency (A&E) department
- Around 2.7% (1,973) will sustain a fracture, of which 28% (568) will be a hip fracture
- These estimates are in keeping with the fracture related, non-elective (emergency) admission data for Liverpool, although actual 2012 figures are slightly lower.

Of the Core Cities, Liverpool had the second highest rate of falls among the over-65s (2007-2011), significantly higher than both regional and national levels. The rate in Liverpool is almost 6 times that in Nottingham.

Costs

Where total costs to health services are known, the impact for patients aged over 65 in Liverpool is estimated at a minimum of £7.2 million. This is a conservative estimate based on identifiable spend, with the greatest proportion of spend as a result of emergency hospital admissions (£4,085,439)[6].

In Liverpool during 2013/14, the peak times of the year for admissions were during December, January and April there were 3,868 non elective hospital admissions from residential settings:

- 1,339 Nursing homes
- 2,529 Care homes and intermediate care

Falls in Community Settings of Care

There are general measures that can be taken to reduce the risk of falling and harm from falls for all residents/clients users by taking into consideration each resident's/client's individual risk. Assessing a resident/client risk of falls/fractures followed by personalised care planning to manage risk is key to fall/fracture prevention and management in community settings of care. There is evidence that residents are particularly at risk from falls and fractures in the first few months after admission to a residential setting. This may be due to the environmental changes and/or a period of ill health prior to admission. It is therefore essential that you assess residents for their risk of falling and put a care plan into practice to manage risk as soon as possible [4].

Falls and injuries in community settings of care are more common because:

- Residents/clients are more likely to be physically frail
- Residents/clients may be physically inactive, which leads to muscle weakness and poor balance
- Many residents/clients may have long term conditions which can increase the risk of falling such as; strokes, Parkinson's disease, arthritis, depression and dementia
- Residents/clients may be taking a number of medications
- New residents are less familiar with their new environment

Consequences of older people falling/long lies

Physical	**Psychological**
• Immobility • Incontinence • Cuts, bruises, soft tissue injuries • Fractures • Chest infections • Head injuries • Dislocation • Pressure ulcer/leg ulceration • Dehydration • Hypothermia • Death	• Increased dependency • Emotional distress • Loss of control • Social isolation/withdrawal • Fear of future falls • Low self esteem • Embarrassment • Anxiety/depression • Loss of confidence • Carer stress

There is a good practice self-assessment tool that residential settings can use to compare their working practices in their setting with evidence based good practice available at:

http://www.laterlifetraining.co.uk/wp-content/uploads/2011/07/Falls-and-fractures-guidance-care-homes-interactive-V3.pdf

Falls risk assessment

A multifactorial risk assessment should be carried out for everyone new to the care setting within 24 hours of admission and all current residents should have one in place. This information should then be used to complete a falls care plan, this will identify some of the risk factors a resident may be exposed to. The multifactorial risk assessment should include an osteoporosis risk screen which is an assessment of bone health; this is due to a fall being more likely to result in a fracture if a resident has osteoporosis.

Multifactorial falls risk assessment

This is an assessment with multiple components that aims to identify a person's risk factors for falling. This assessment should be performed by a healthcare professional with appropriate skills and experience. It should be part of an individualised, multifactorial intervention. A multifactorial falls risk assessment may include the following:

- identification of falls history assessment of gait, strength, balance and mobility
- assessment of fracture risk assessment of perceived functional ability and fear relating to falling
- assessment of visual impairment assessment of cognitive impairment and neurological examination assessment of urinary incontinence assessment of home hazards falls in older people
- cardiovascular examination and medication review.

The care plan should be shared with the resident and their family and where there are concerns about a resident's capacity to understand the risk and implications of falling, capacity must be assessed under the Mental Capacity Act and if needed a best interest decision made to maintain the resident's safety. The outcome of this assessment must be recorded in the person's care plan.

Where a resident/service user falls and a falls risk assessment is in place which has been followed, then it is not necessary to report the incident as a safeguarding concern.

This guidance recommends that there should be one single document for a resident/service user which contains evidence of:

1) The factors contributing to any falls risk (Intrinsic and extrinsic factors) for an individual
2) Actions taken to reduce the risk
3) Actions yet to be carried out
4) A statement predicting the risk of future falls – this should be based on the evidence collated and must be discussed with the family from the outset.

This information should appear in one document so that in the event of an enquiry of a fall the investigator can see evidence of action taken to address risk without having to trawl through daily reports and other documents to find information. (See Appendix 3 - Falls action plan evidence document.)

In terms of a falls risk assessment, care planning and risk management, there are a number of key points in a resident's/client's journey of care:

- pre admission to the care/nursing home/ intermediate care/home care
- admission to the care/nursing home/ intermediate care/home care
- at any point when the resident/service user's needs change
- after a fall
- after a change in medication

- on transfer from another setting, e.g. discharge from hospital
- at a routine review as a minimum every 6 months

Where a resident/client sustains an injury due to a fall and there is a concern that a risk assessment is not in place or was not followed, then this must be reported as a safeguarding concern because this amounts to neglect on the part of the care provider.

'Unwitnessed' falls/unexplained injury

There has been an expectation that care providers should raise safeguarding concerns in respect of all 'unwitnessed falls'. However, this broad approach is not helpful, nor is the use of the term 'unwitnessed fall' - if a fall is unwitnessed, how can it be determined that the person fell? Could it be possible that they were pushed or knocked over by someone else? In some circumstances it may be presumed that the person fell, for example, if they are found on the floor in their room and no one else is around; but each individual incident needs to be considered according to the unique factors of the case.

On occasions 'unwitnessed falls' have been reported as safeguarding concerns even when the person has stated that they fell. If there is a risk assessment in place which has been followed then it is not necessary to raise a safeguarding concern, the person has explained what happened and abuse or neglect is not likely to have occurred.

In this context it is more helpful to use the term **'unexplained injury'** rather than 'unwitnessed fall'. In circumstances where a person has sustained an injury, the manager on duty should use judgement based on the evidence available to determine what may have happened. If the person has an injury, other than a minor injury, which cannot be explained, then this should be referred as a **safeguarding concern.**

Where a person has repeat unexplained injuries then a safeguarding concern should be raised

Providers are required to report to CQC any serious injuries to people who use the service (Regulation 18) http://www.cqc.org.uk/content/regulation-18-staffing

Seeking medical advice following a fall (Appendix 2 – Liverpool falls care pathway for community settings of care)

Every fall may not require GP or hospital involvement; this will depend on the nature of the injury, the experience of staff in the care service and whether there is a trained nurse on site, expectation of family etc. If no injury is apparent, there is no observed change in function and actions and observations have been recorded, then a GP or hospital review may not be necessary. This decision will be made by the manager or clinician on duty based on the individual circumstances of the case. Please refer to the Liverpool Falls Care Pathway for further information on interventions required and referral pathway (Appendix 2).

A post-fall protocol should include:

- checks by nursing staff for signs or symptoms of fracture or potential for spinal injury before the patient is moved
- safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury (community hospitals and mental health units without the equipment or expertise may be able to achieve this in collaboration with emergency services)
- frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (for example, unwitnessed falls) based on the NICE guideline on head injury
- timescales for medical examination following a fall (including fast track assessment for patients with signs of serious injury, or high vulnerability to injury, or who have been immobilised); medical

examination should be completed within a maximum time period of 12 hours, or 30 minutes if fast-tracked.

What is head injury?

A head injury is a blow to the head from a force outside the body, like an accident, fall or attack. When the brain is damaged by such an event, this is called a traumatic brain injury (TBI). Where the person has sustained a head injury, a medical assessment should always be arranged as a matter of urgency. The following definition of head injury can be found in **'**Head Injury' (2013)
http://www.brainandspine.org.uk/sites/default/files/documents/Head%20injury%20A5%20(2).pdf

What are the symptoms?

The symptoms and effects of head injury can vary widely, depending on the level of injury and which part of the brain, if any, is injured. **They can range from a bump or bruise on the head to loss of consciousness.**

Falls in hospitals

Falls in hospitals require a different response; Hospital Trusts have their own governance arrangements in relation to patient safety, including falls, and should follow their own procedures.

Summary of when to raise a safeguarding concern following a fall

It is important to remember that a safeguarding concern must be raised where there is a concern about possible abuse or neglect *by another person* and not because there is a general concern about a person's safety.
Where a resident sustains an injury due to a fall, and there is a concern that a risk assessment was not in place or was not followed, this must be reported as a safeguarding concern. The key factor is that the person has experienced *avoidable* harm.

Where a person has an injury, other than a very minor injury, which is unexplained, this must be reported as a safeguarding concern.

Or

Where a resident has sustained an injury which has resulted in a change in function and appropriate medical attention has not been sought, this must be reported as a safeguarding concern.

If in doubt raise a safeguarding concern, the professionals based in Careline will then decide how to proceed

Good practice suggests: [4]

- updating the assessment and care plan every month
- reviewing falls risk assessment and care plan every six months as a minimum
- there must be a complete review of both assessment and care plan
  - (a) Following a fall
  - (b) When there is a significant change in a person's condition. i.e. during/ following illness
  - (c) On transfer from another care setting i.e. discharge from hospital
- completing a falls diary for each person, the staff member in charge of care should examine and analyse the information so that in the event of a fall all relevant documentation is completed such as an accident form and RIDDOR notification if required.
- all members of the care team should be aware of and involved in the assessment, care planning and evaluation of risk of falls.
- involving the appropriate health professional e.g. GP, district nurses, community matrons, falls clinic, physiotherapy, occupational therapists and dietician as and when required and follow their advice.

It is really important to establish all the causes of a fall so that you can take action to reduce the risk of further falls; you need to clarify the facts:

? what exactly happened
? where (exact location)
? when (date and time of day)
? who was involved
? how did it occur

Thresholds for raising a safeguarding concern in respect of a fall

Easy Guidance

When should a fall be reported through safeguarding procedures?

- Where a person sustains an injury due to a fall, and there is a concern that a risk assessment was not in place or was not followed, this must be reported as a safeguarding concern. The key factor is that the person has experienced *avoidable* harm

- Where a person has sustained an injury which has resulted in a change in function and appropriate medical attention has *not* been sought, this must be reported as a safeguarding concern

- Where a person has an unexplained injury, other than a very minor injury, this must be reported as a safeguarding concern.

When don't I need to raise a safeguarding concern?

- A safeguarding concern does not need to be raised when a person is found on the floor, is not injured and appropriate risk assessment is in place and has been followed

- A safeguarding concern does not need to be raised when a fall is witnessed and appropriate risk assessment is in place and has been followed

- A safeguarding concern does not need to be raised when the person has capacity to understand what happened and states that they fell.

Note: The threshold for safeguarding is met when harm has occurred and there is a concern about possible abuse or neglect *by another person.* Accidental falls do not meet the threshold for Safeguarding when a risk assessment is in place and has been followed.

This document is intended to offer guidance to managers in making decisions but it is acknowledged that at times there may be incidents where decision-making is not straightforward and professional judgement is required. In all cases ensure that the reasons for the decision are recorded.

If in doubt raise a safeguarding concern 0151 233 3800, the professionals based in Careline will then decide how to proceed.

Appendix 1 Practice example – Risk assessment

Example of falls evidence document Re: Doris S 20/08/28

Triggers for falls

Vascular Dementia (established)

Previous NOF (March 12)

Mobility problems (uses a zimmer frame under supervision)

Diabetes Type 2 with probable associated neuropathy/ vascular issues

Continence problems

General frailty BMI 20 / weight 50 Kg

History of recent repeated chest infections

History of 3 x unwitnessed falls in her bedroom – she will get out of bed during the night without asking for help and will be unlikely to use zimmer frame appropriately when alone.

Actions completed

GP asked to review night time medication as most predictable time for incidents to occur – reviewed and no further intervention suitable.

Low rise bed in place, plus crash mat / bleep mat.

Most frequent possible checks made at night time.

Options Health Assessment done.

Falls Team asked for advice / responded on 14/02/13.

Walking aid assessment done and no other walking aid suitable.

Communication with the family about risks and actions already completed.

Actions to do

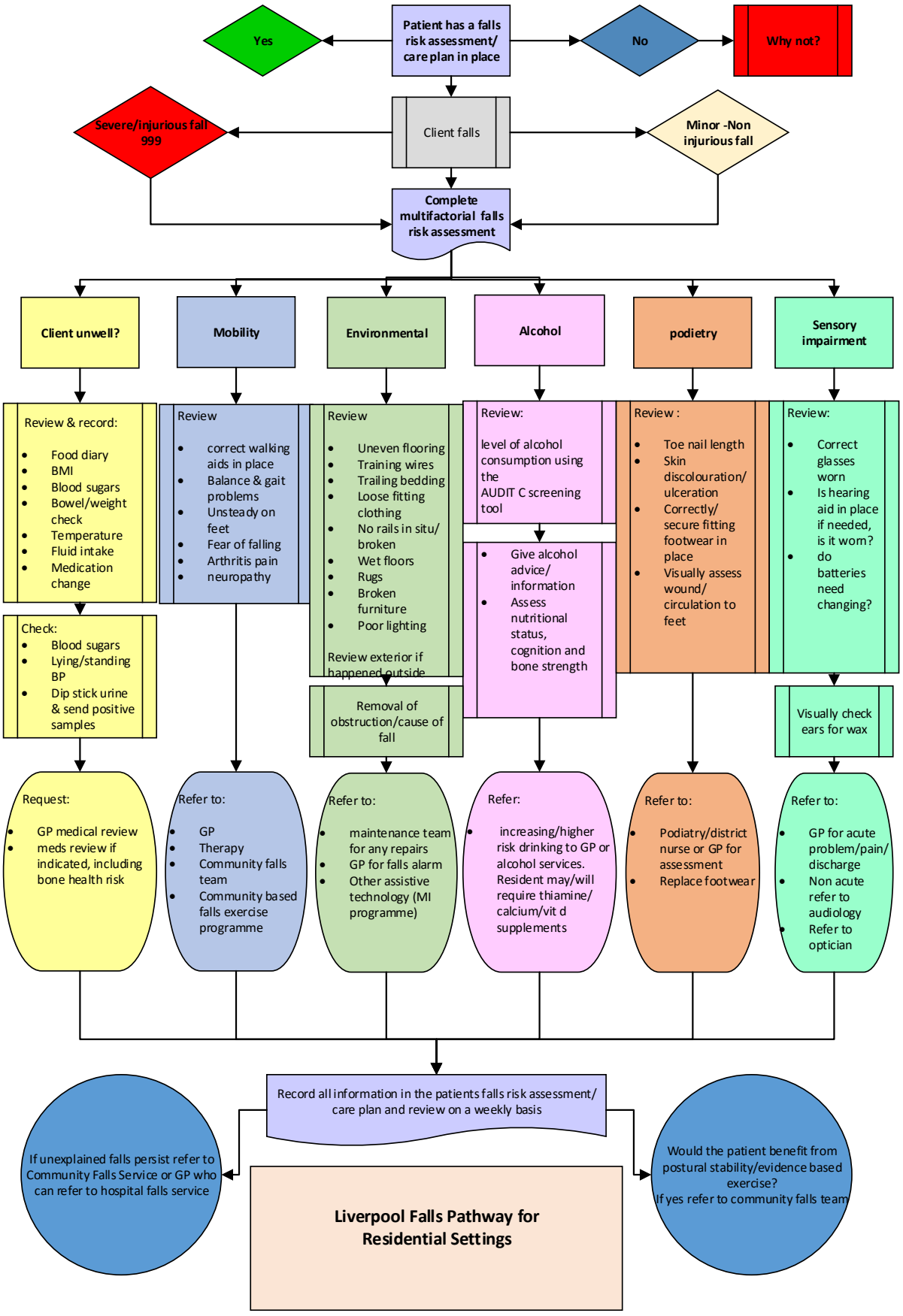
Update family on advice from the Falls Team.

Highlight the risks, real and potential for the future and whether there is any need to ask for re-assessment of need / placement.

Ask for repeat lying / standing BP from Options team on next visit as BP low on 14/02/13.

Statement As detailed above Doris does have a very high risk of falls and despite all the above actions it is evident that she will be likely to have further falls in the future.

Appendix 2
Liverpool Falls care pathway for residential settings



Template Action Plan Appendix 3

Name of resident	Time & Date of Fall (When)	Location of fall (Where)	Witness/1st on scene (who was involved)	Explained/Un-explained	Injury Received (What happened & How did it occur)

Reason for fall	Action Taken	Action Taken	Referral	Risk Assessment Review (Date)	Action Plan Review undertaken (Date)

Full Name …….. Signed …… Date.....……Designation…….....

Appendix 4
Risk factors/triggers for falls in older people

Risk factors/triggers for falls

ACTIONS COMPLETED
ACTIONS TO DO
MAKE A STATEMENT ABOUT RESIDENTS FUTURE RISKS

Signature…….

Designation…….

Date……Time……

Appendix 5

For guidance on working out units:

http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:

A total of 5+ indicates **increasing** or **higher risk** drinking.

An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 **Lower risk**, 8 – 15 **Increasing risk**,
16 – 19 Higher risk, 20+ **Possible dependence**

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions

References

(1) Falls Prevention exercise: Following the evidence Age UK

http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Falls_Prevention_Guide_2013.pdf?dtrk=true

(2) Older People in Care homes; NICE Briefing

http://www.nice.org.uk/advice/lgb25/resources/older-people-in-care-homes-60521208572869 [accessed 2nd July 2015]

(3) Falls in Older People: assessment after a fall and preventing further falls: NICE Quality Standard 86 https://www.nice.org.uk/guidance/qs86

(4) Managing falls and fractures in care homes for older people

http://www.laterlifetraining.co.uk/wp-content/uploads/2011/07/Falls-and-fractures-guidance-care-homes-interactive-V3.pdf [accessed 8th July 2015]

(5) Older People in Care Homes (2015) NICE Government Briefing

http://www.nice.org.uk/advice/lgb25/resources/older-people-in-care-homes-60521208572869 [accessed 8th July 2015]

(6) Liverpool City Council and Liverpool CCG, JSNA (2013) Adults and older people: Falls and Fragility Fracture Prevention.

http://liverpool.gov.uk/media/688715/adultsolderpeoplefalls.pdf [accessed 14th July 2015]

Knowsley SAB - guidance for responding to falls

Appendix F Safeguarding enquiry outcome provider report

Adult Social Care & Health

Safeguarding enquiry outcome report

The information below is essential data that Liverpool City Council is required to collect and collate. The Care Quality Commission will scrutinise the systems for capturing initial data, the outcomes of the enquiry and the learning from this. The quality of our intelligence will form a crucial part of all inspections.

Liverpool City Council has received the following safeguarding concern in relation to your service or your service user.

On receipt of this request from Careline please e-mail SALEVEL1@liverpool.gcsx.gov.uk BEFORE you start your enquiry for further instructions and to find out the name of the officer who will be dealing with the safeguarding enquiry.

Please carry out an internal enquiry to ascertain:

1. what happened
2. why did it happen
3. what you have put in place to prevent it happening again
4. what does the adult at risk want as an outcome

Please complete this document and forward to the Quality Assurance Adult Safeguarding Unit by email: SALEVEL1@liverpool.gcsx.gov.uk within 14 days.

Service User Details	
First Name	**Surname**
Address	
Date of Birth	**LAS No.**
Date Referral Received	

Allegation Details (as stated on the referral to be completed by Careline):

Does the person require the support of an independent advocate? (To be completed by Careline see guidance notes)

Service user's desired outcomes at the first point of contact (To be completed by Careline. If this is not known, Careline will include this in the points to be addressed by the provider)

Provider enquiry into the allegation must include a response to the following points (To be completed by Careline):

The following sections to be completed by the provider

1. Internal enquiry to be completed by the provider (to include):

a) **Discussions with service user or where applicable their representative/advocate**

b) **Dates of discussions/meeting(s):**

c) **Service user's desired outcomes at the first point of contact:**

d) **What were your findings/evidence from the enquiry (your internal enquiry into the allegation must include a response to the points raised by Careline):**

2.What did you conclude:

3.Recommendations implemented to minimise the risk(s) re-occurring:

(Please note in order to quality assure the process the QAASU may visit to ensure these recommendations have been implemented).

4.Date for review of recommendation(s):

5.To be reviewed by whom:

6.Overall conclusion
Tick one box only

Evidence shows abuse occurred **Substantiated**	
Evidence shows abuse **Partially substantiated**	
Suspicions remain but there is no clear evidence **Inconclusive/Undetermined**	
Evidence shows abuse did not occur **Unsubstantiated**	
The enquiry was ceased at the service user's request	

7.Service user's desired outcomes at the first point of contact:

8.Have the service user's desired outcomes changed from the first point of contact Yes/No

9.If yes please provide details:

10.What were the service user's outcome/s that were either met/not met. Please explain including the service user's/representative/advocate feedback

Outcome	Fully achieved /partially achieved /not achieved

11. Service User's feedback (please provide any feedback from the service user e.g. how they felt about the safeguarding enquiry)

12. Actions taken by the provider / Please tick one box for alleged victim and one for alleged perpetrator

Alleged Victim		Alleged Perpetrator	
Increased monitoring		Criminal prosecution	
Removed from property or service		Police action	
Community care assessment and services		Disciplinary action	
Civil action		Community care assessment, service	

Court of Protection		Management of access to alleged victim	
Change of appointeeship		Referral to DBS	
Management of access to finances		Referral to professional body	
Referral to advocacy scheme/IMCA		Action by CQC	
Referral for counselling		Action by Health care Commission	
Increase/different care package		Continued monitoring	
Action under Mental Health Act		Counselling/training/treatment	
Review of direct Payments/Support		Referral to Court Mandated Treatment	
Management of access to alleged perpetrator		Action under Mental Health Act	
Declaratory relief		Review of care plan/risk assessment	
Referral to complaints procedure		Action by placing authority	
Service user refused intervention		Management action, supervision, training	
Guardianship		Carers assessment	
Safeguarding Adults review		Safeguarding adults review	
Action by placing authority		No Further action	
Review of care plan/risk assessment		Contract of agency suspended	
No Further action			
Other **please specify**		Other **please specify**	

13. Date enquiry concluded:

14. Enquiry completed by:

15. Manager's signature:

16. Organisation

Guidance notes

These guidance notes are for the purposes of recording your enquiry only. The guidance here is not meant to replace the relevant sections in the safeguarding adults policy and procedure

The objectives of an enquiry into abuse or neglect are to:

- establish the facts
- ascertain the adult's views and wishes
- assess the needs of the adult for protection, support and redress and how they might be met
- protect from the alleged abuse and neglect, in accordance with the wishes of the adult
- make decisions as to what follow up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and
- enable the adult to achieve resolution and recovery.

Allegation

The first task when you are reviewing the information on the referral is to identify exactly what the safeguarding concerns are that you need to make enquiries about.

Break down the story into specific allegations and this will enable you to focus on what kind of abuse is actually being alleged and who is being alleged to have perpetrated the abuse. **For example**; if a service user has developed a pressure wound whilst in the care of a provider then the allegation may be, **neglect in that the service provider failed to provide the necessary care to prevent a pressure wound developing**. If a service user has been given the wrong medication then an allegation of physical abuse is indicated in that the service user was given a non prescribed medication.

Try and be clear that at this stage, you are identifying the allegation not the reason or motivation of the alleged perpetrator. For example; a carer may have verbally abused a service user. Their motivation may well be that they are stressed but that doesn't change the impact of harm on the service user. If the service user is harmed or at risk of being harmed then regardless of the motivation or reason for the action, it is abuse.

Making Safeguarding Personal (MSP)

MSP means the safeguarding enquiry should be person-centred and outcome-focused. It means having a conversation with the service user about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control, as well as improving quality of life, wellbeing and safety. At the beginning of the safeguarding enquiry you must ascertain the service user's views and wishes. What does the service user want to happen?

Any conversations that relate directly to the service user or to decisions involving them must always include them or their representative or advocate. The service user must be kept involved throughout the enquiry unless it would increase the risk of abuse or neglect.

Independent advocate

At the beginning of an enquiry, the local authority has a duty to consider whether the adult requires an independent advocate to represent and support them in the enquiry.

An independent advocate should be provided to an adult who would have 'substantial difficulty' in doing one or more of the following:

- understanding relevant information
- retaining that information
- using or weighing that information as part of the process
- communicating their views, wishes or feelings; and
- there is nobody else that is appropriate and able to represent them.

This should be kept under review as the enquiry progresses

Enquiry/Chronology/Contacts

You must record all of your actions in this section. They could be phone calls; meetings, visits, etc. Where you have collected or identified evidence you should record this in the following section, making reference to it in this section.

An example of this is as follows:

Chronology/Contact
6/06/2015 Reviewed care notes (Paragraph 1; Evidence section)

07/06/2015 Interviewed care worker

Findings/Evidence

1. There was no evidence that the care plan had been updated in relation to the service user's change of medication etc

This section will contain all of the detail, in chronological order, of your discussions/ meetings.

Findings/Evidence

These relate to the evidence you have gathered specifically with regard to the allegations that were identified at the outset of the enquiry and the service user's desired outcomes. The findings will corroborate or refute the initial allegation(s). You should record anything you feel is significant to the enquiry in this section. This could be:

- direct evidence from the victim themselves, what they have experienced
- hearsay evidence or what a person has heard from another person
- circumstantial evidence, which may not be based on the facts in question but which supports the case, e.g. evidence of bruising immediately following a shift worked by a particular worker.

This evidence may take the form of documents you have reviewed, care notes, interviews you have conducted, photographs of injuries, etc.

Conclusion(s)

Your conclusion(s) will be directly informed by your findings. Each allegation must have a conclusion and you must state why you have come to the relevant conclusion. In order to do this you will need to analyse the evidence you have gathered, decide on its relative strength and consider whether it corroborates or refutes the initial allegations.

There should be one conclusion for the overall enquiry:

- ***Substantiated*** where evidence indicates that the abuse occurred as alleged
- ***Unsubstantiated*** where evidence indicates that the abuse did not occur as alleged or there is no evidence to support the allegation.
- ***Not determined/inconclusive*** where it is not possible to record an outcome against any other category, where suspicions remain but there is no clear evidence
- ***Partially substantiated*** where it has been possible to substantiate some but not all of the allegations (e.g. it was possible to substantiate an allegation of physical abuse but it was not possible to substantiate an allegation of financial abuse).

Service user outcomes

Has the service user's outcomes been achieved? e.g.

- the service user feels safer
- the service user has maintained key relationships
- the service user has received an apology/access to justice
- the service user knows how to protect themselves in the future.

It is always best to use the service user's own words

Feedback from service user

Please include any comments provided by the service user/their representative or advocate in relation to the safeguarding enquiry e.g. how they felt about the safeguarding enquiry, if they feel the enquiry has made a difference to them, were they satisfied with the outcome of the enquiry etc.

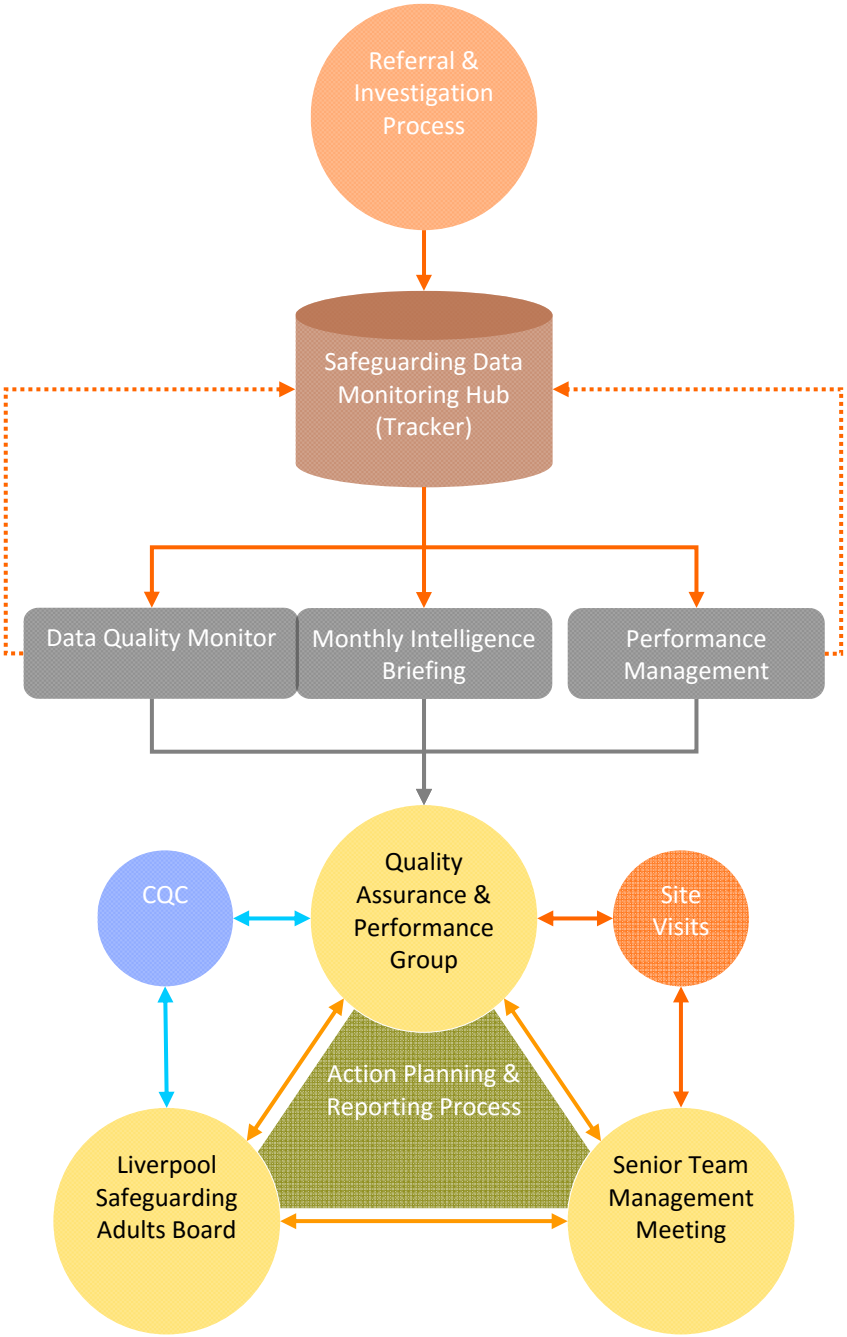
Recommendations

These must be reasonable and should identify who you think needs to take responsibility for following them up. For example, if a care plan needs to be reviewed in relation to falls then the recommendation needs to indicate who be responsible for this action.

Appendix G Quality assurance

Liverpool has a robust monitoring and quality assurance process in place which meets the requirements for the Department of Health statistical returns. These systems are monitored and updated regularly to ensure that they are current and relevant.

The chart below demonstrates the functions Liverpool adult safeguarding has in place to monitor and quality assure safeguarding referrals through to closure. The monitoring of individual service users and providers including the monitoring of social work safeguarding practice. This allows a 360 degree focus on the safeguarding functions in adult services.



Appendix H Police referral form

PLEASE NOTE THIS FORM MUST BE EMAILED TO LIVERPOOL PROTECTING
VULNERABLE PERSONS UNIT (PVPU) – please complete two pages and email to:
Liverpool.MASH@merseyside.pnn.police.uk

Details of Alleged Victim				
Name and Alias/AKA (if known)	**Age / Sex**	**DoB**	**Address**	***Place of Birth***

If other victims, please give details

Name and Alias/AKA (if known)	**Age / Sex**	**DoB**	**Address**	***Place of Birth***

Type of Abuse (put x in box)									
Physical		Sexual		Financial or material		Neglect and acts of omission		Psychological	
Organisational Abuse		Domestic Abuse		Discriminatory Abuse		Modern Slavery		Self-Neglect	

Outline of Events including: dates, times, names of those involved, full venue address and post code to be included

Detail of alleged victims capacity, medical conditions, willingness / ability to be interviewed

Service User Group of Victim (put x in box)									
Learning Disability		Mental Health		Physical Support – over 65 years		Substance Misuse		Physical & Sensory Impairment	
Support with Memory - EMI		Carer		Other		Please detail:			

Details of Alleged Perpetrator/s Only if known			
Name and Alias/AKA (If known)	**Age / Sex**	**DoB**	**Address (including all contact details if known)**

Information Relating to Perpetrator/s: including relationship to service user

Witness Details PLEASE SUPPLY THE FOLLOWING: DATE OF BIRTH, ADDRESS, CONTACT DETAILS, ANY DISCLOSURE OR WITNESS REPORT THEY MAY HAVE MADE TO BE ATTACHED	
Name	**Details**

Involvement with social services to date, including any actions taken by practitioner in relation to referral

Details of Person Completing this Form	
Name:	
Designation:	
Team:	
Line Manager Name:	
Telephone: Direct line or mobile **– not Careline**	
Fax:	
Email:	
DATE:	

Appendix I Merseyside Risk Identification Tool (MeRIT)

Name of victim:

	ALL QUESTIONS MUST BE TICKED	Y	N
1	Are there issues around separation/divorce, regardless of timescale?		
2	Is the victim pregnant?		
3	Are there any child contact issues?		
4	Is the victim socially isolated?		
5	Is there emotional abuse present?		
6	Is there financial abuse present?		
7	Is there extreme jealousy present?		
8	Have threats been made to the victim?		
9	Has the victim been harassed/stalked? (By the perpetrator or a 3rd party related to the perpetrator)		
10	Is the victim a repeat victim (known to your agency)?		
11	UNREPORTED previous incidents? (if so, how many?)		
12	Does the victim have a learning disability and/or mental health issues?		
13	Does the perpetrator have a learning disability and/or mental health issues?		
14	Have the incidents escalated on terms of severity and/or frequency?		
15	Is the victim unemployed?		
16	Is the perpetrator unemployed?		
17	Does the perpetrator have a history of violence?		
18	Has the perpetrator ever been violent to the children? (or made threats of violence to children)		
19	Has the perpetrator even been violent to pets? (or made threats of violence to pets)		
20	Has the perpetrator ever self harmed/threatened to self-harm and/or threatened suicide?		
21	Has the perpetrator ever sexually abused the victim or been sexually inappropriate? (including threats)		

BACKGROUND TO THE RELATIONSHIP

(If applicable include information on injuries to the victim and/or their demeanour)

	ALL QUESTIONS MUST BE TICKED	Y	N
22	Alcohol present (perpetrator only)		
23	Alcohol present (victim only)		
24	Alcohol present (both)		
25	Drugs present (perpetrator only)		
26	Drugs present (victim only)		
27	Drugs present (both)		
28	Is the victim un-cooperative?		
29	Does the victim appear afraid? (please note demeanour)		
30	Does the victim feel s/he is at risk? (if yes, give details)		
31	Does the victim deny an assault has taken place (when there are signs of an assault)?		
32	Were children present? (If so where?)		
33	Did children witness the incident?		
34	Was there damage to the property/belongings?		
35	Was there physical violence?		
36	Were the victim and perpetrator violent to each other?		
37	Was violence used in self-defence?		
38	Did the perpetrator strangle/attempt to strangle or place his/her hands around the victim's throat?		
39	Was a pre-meditated weapon present?		
40	Was an opportunity weapon present?		

WHAT HAPPENDED LEADING UP TO AND DURING THE INCIDENT

Please place a cross in each box that correspond to the question number, where an answer of 'yes' was provided.

SIGNIFICANT FACTORS	BREAKDOWN	VIOLENT
	1.	
2.		
	3.	
		4.
		5.
		6.
		7.
	8.	
	9.	
10.		
		11.
12.		
13.		
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		30.
31.		
	32.	
	33.	
		34.
		35.
36.		
37.		
		38.
		39.
		40.

Add the total number of ticks for each column and place in the corresponding box below. Then multiply the total number of ticks in each box (e.g. 12 x 3 x 6 = 216)

SIGNIFICANT FACTORS	BREAKDOWN	VIOLENT	**TOTAL**
x	**x**		**=**

Completed by …… Date ……

Agency ……

Level of Risk	**Guidance on interventions** (this is not an exhaustive list)
HIGH = 72+	• Referral to MARAC • Referral to IDVA to be considered • Multi-agency work, information sharing and action/safety planning • Sanctuary/target hardening (where it is safe to do so) – security measures, mobile phone etc • Police intervention – arrest and investigate • Legal protection – Specialist Domestic Violence Court (SDVC), family courts. • Refuge, emergency accommodation • Safeguarding interventions – children and adults • Drug and alcohol services, mental health issues • Additional barriers – forced marriage, street sex workers, immigration status.
MEDIUM = **16 - 71**	• Multi-agency work – information shared • Information about services and options • Support – safety planning • Specialist support services from within domestic violence (abuse) sector • Sign posting to specialist support services • Sanctuary – if there is a risk of homelessness • Target hardening
STANDARD = **1-15**	• Individual agencies responsive to the client's needs – housing, children's services, health, education. • Universal services. • Consider Sanctuary – if there is a risk of homelessness • Leaflets/awareness raising

Appendix J Channel referral and assessment form

Referral and Assessment Form

Person making referral: ……...

Contact number: ...……

Subject's Surname		**Forename(s)**	
D.O.B & Place of birth		**Male/Female**	
Address			
Tel No(s) Mobile		**Email**	
School or Employment			

Reason for referral

Household composition

Name	**D.O.B**	**Gender**	**Relationship to subject**

Other Significant Adults

Name	D.O.B	Gender	Address	Relationship

Agencies Involved	Contact	Telephone	Email

Assessment: Please complete the following, alternatively you may attach a completed CAF or ASSET or APIR

Family History, functioning and well-being *(Illness, bereavement, violence, drug use, criminality, relationship breakdown)*

Participation in learning, education and employment *(Attendance and achievement, personal and social development)*

Health
(Physical and mental well-being. The impact of genetic factors and of any impairment need to be considered)

Emotional/Social Development
(Confidence, psychological difficulties, coping with stress, adaptation to change)

Identity, Self Esteem, Self Image and Social Presentation
(Perceptions of self, sense of belonging, experiences of discrimination, acceptance by family, peer group and wider society, understanding of the way in which appearance and behaviour are perceived by the outside world and the impression being created)

Based on the above, what are the key needs of the subject?

Based on the above what do you think is the impact/risk for the subject?

This form should be emailed to: **carelineadultservices@liverpool.gcsx.gov.uk**

Appendix K Agenda for safeguarding adults strategy meeting

This meeting is being called under the inter-agency safeguarding adults procedures. The strategy meeting is an inter-agency forum to plan the most appropriate way forward with the enquiry.

1. **Introduction and Apologies**

2. **Members are reminded of the confidential nature of the information shared at the meeting. If information is to be shared outside of the meeting it is to be done on a need to know basis only.**

3. **State and Check Details of Person the meeting is in relation to.**

4. **Details of the Cause of Concern.**

5. **Has the consent of the person been sought? If not, or the person has refused to give consent state reasons for overriding the wishes of the person.**

   Does the service user have capacity to consent?

   Best Interests Decision

6. **Relevant Background Information**

7. **Risk Assessment Document**

8. **Planning the Enquiry**

   - which agency will take the lead
   - the responsibility of all agencies involved.

9. **In deciding the course of the enquiry the following need to be considered:**

   - the wishes of the person (What the person wants as an outcome)
   - is a mental health assessment required – if so who will organise for an appropriately qualified person to carry this out
   - if there is sufficient evidence for a police investigation
   - if other agencies need to be involved
   - if disciplinary procedures need to be instigated
   - no further action.

10. **Protection Planning**

    Agree short and long term plans/actions to minimise the risk and protect the service user and who will be responsible for the protection plan

11. **Summary of actions agreed**

Appendix L Statement sheet

Council Logo

Liverpool City Council
Statement Sheet

Statement taken from……

Statement taken by……

Date

NB Address and Signature Required Overleaf

Address…….
……
…….

Telephone…….Mobile……

Date of Birth……..

Interviewer…….Signature
Interviewee……...Signature

Appendix M Adult safeguarding plan

Service User:	**DOB:**
Address: **Postcode:**	**I.D Number:** **NHS Number:**
Telephone Number:	

Identified Risks/Risk Management

Safeguarding Plan				
Outcome Desired	**Action Needed**	**Person Responsible**	**Time Scales**	**When and how this will be reviewed**

Any other significant details:

Who should have a copy of this plan?		
Service User	**Advocate(s)**	**Service Provider(s)**
Who will review this plan?		
Date of safeguarding plan review?		

Completed by: **Date:**

Adult safeguarding plan guidance notes.

An adult safeguarding plan is the agreed set of actions and strategies that are designed to support and manage ongoing risk of abuse or neglect for an adult with care and support needs.

Adult safeguarding plans should be person-centred and outcome-focused. Adult safeguarding plans should be made with the full participation of the adult, or their representative or advocate as appropriate. Wherever possible, safeguarding plans should be designed to reflect and aim to achieve the adult's desired outcomes. The aim is to manage risks in ways which improve the quality of life of the person to promote their independence.

Identified Risks/Risk Management

When identifying risks please ensure that any patterns of behaviour or past risks that are relevant are included. Please include the severity of each identified risk and the likelihood of such a risk re-occurring.

Risk management strategies and measures should be personalised to the individual circumstances and context of the adult. It is also about ensuring any support the adult needs to manage risk of abuse or neglect, including measures that may need to restrict or control an adult's choices and freedoms. It is tailored to their individual circumstances, and takes account of their history, preferences, culture and values.

Where an adult chooses to accept risks, the safeguarding plan must include details of how individuals will be supported to understand that risk, including being given appropriate training, information and strategies to minimise the risk or make different choices.

Please include contingency planning if the safeguarding plan in place is not meeting needs or if there is still risk. If the adult at risk refuses services or interventions, strategies must be put in place to ensure there is ongoing work to support, and where possible, protect individuals. If the adult at risk makes repeated unwise choices, or makes decisions that are out of character or irrational, a capacity assessment should be considered.

Safeguarding plan

This should include the desired outcome(s) to be achieved, what action(s) are necessary to achieve the outcome (s), who is responsible for the action(s), when and how this will be monitored and the responsible person(s) e.g. **desired outcome:** maintain relationships with perpetrator of abuse, **action necessary** may include supervised visits via court of protection order, if visiting service user in supported accommodation visit in communal areas leaving doors open etc, **person responsible** provider agency ensuring the service user is not put in a vulnerable position with the perpetrator, **timescales** immediately, **When and how will this be reviewed** social worker to review actions in 6 weeks unless concerns are raised.

Any other relevant information

Please include any information relevant to the service user that is not detailed in the risk management/safeguarding plan. This includes other actions that may impact on the plan. i.e. recommendations for the service provider, Care Quality Commission action plans, any civil action recommended to the adult or their representative, support provided to the carer, details of support to the adult if there is to be ongoing legal actions and any risks to others and actions to deal with this.

Who should have a copy of this plan?

This plan is confidential and should be shared with the consent of the adult with those people/agencies responsible for implementing the necessary actions to safeguard the adult of risk of abuse or neglect. Where the adult lacks capacity then a best interest decision should be made.

Appendix N Safeguarding enquiry outcome report

Adult Social Care & Health

Safeguarding enquiry outcome report

The information below is essential data that Liverpool City Council is required to collect and collate. The Care Quality Commission will scrutinise the systems for capturing initial data, the outcomes of the enquiry and the learning from this. The quality of our intelligence will form a crucial part of all inspections.

Service User Details	
First Name	**Surname**
Address	
Date of Birth	**LAS No.**
Date Referral Received	

Allegation (as stated on the referral):

Service user's desired outcomes at the first point of contact:

Does the person require the support of an independent advocate? (See guidance notes)

Chronology/Contacts (to include):

a)Discussions with service user or where applicable their representative/advocate

b) Initial network planning (as agreed following discussion with team leader/manager)

c) Strategy discussions/meetings

d) Dates of discussions/meeting(s):

e) Findings/Evidence from the enquiry:

Conclusion:

Safeguarding plan

Officer responsible for monitoring the safeguarding plan:

Recommendation(s):

Date for review of recommendation(s):

To be reviewed by whom:

Closure/meeting/ letter sent: Yes ☐ No ☐

Date of closure meeting/ letter sent:

Overall conclusion

Tick one box only

Evidence shows abuse occurred **Substantiated**	
Evidence shows abuse **Partially substantiated**	
Suspicions remain but there is no clear evidence **Inconclusive/Undetermined**	
Evidence shows abuse did not occur **Unsubstantiated**	
The enquiry was ceased at the service user's request	

Service user's desired outcomes at the first point of contact:

Have the service user's desired outcomes changed from the first point of contact Yes/No

If yes please provide details:

What were the person's outcome/s that were either met/not met. Please explain including the person's/representative/advocate feedback

Outcome	Fully achieved /partially achieved /not achieved

Service user's feedback (please provide any feedback from the service user e.g. how they felt about the safeguarding enquiry)

Actions taken by social worker/enquiry officer. Please tick one box for alleged victim and one for alleged perpetrator

Alleged Victim		Alleged Perpetrator	
Increased monitoring		Criminal prosecution	
Removed from property or service		Police action	
Community care		Disciplinary action	

assessment and services			
Civil action		Community care assessment, service	
Court of Protection		Management of access to alleged victim	
Change of appointeeship		Referral to DBS	
Management of access to finances		Referral to professional body	
Referral to advocacy scheme/IMCA		Action by CQC	
Referral for counselling		Action by Health care Commission	
Increase/different care package		Continued monitoring	
Action under Mental Health Act		Counselling/training/treatment	
Review of direct Payments/Support		Referral to Court Mandated Treatment	
Management of access to alleged perpetrator		Action under Mental Health Act	
Declaratory relief		Review of care plan/risk assessment	
Referral to complaints procedure		Action by placing authority	
Service user refused intervention		Management action, supervision, training	
Guardianship		Carers assessment	
Safeguarding Adults Review (SAR)		Safeguarding Adults Review (SAR)	
Action by placing authority		No Further action	
Review of care plan/risk assessment		Contract of agency suspended	
No Further action			
Other **please specify**		Other **please specify**	

Date enquiry concluded:

Enquiry completed by:

Team:

Manager's signature:

Guidance notes

These guidance notes are for the purposes of recording your enquiry only. The guidance here is not meant to replace the relevant sections in the safeguarding adults policy and procedure

The objectives of an enquiry into abuse or neglect are to:

- establish the facts
- ascertain the adult's views and wishes
- assess the needs of the adult for protection, support and redress and how they might be met
- protect from the alleged abuse and neglect, in accordance with the wishes of the adult
- make decisions as to what follow up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and
- enable the adult to achieve resolution and recovery.

Allegation

The first task when you are reviewing the information on the referral is to identify exactly what the safeguarding concerns are that you need to make enquiries about or cause others do so e.g. provider, CCG, NHS England etc There may be a long and complex story being described but not all of the issues raised will be safeguarding ones.

The story may well contain issues that cannot be addressed as safeguarding concerns but nonetheless they need to be dealt with. These could be contract issues or they may constitute a complaint about a service.

Break down the story into specific allegations and this will enable you to focus on what kind of abuse is actually being alleged and who is being alleged to have perpetrated the abuse. **For example**; if a service user has developed a pressure wound whilst in the care of a provider then the allegation may be, **neglect in that the service provider failed to provide the necessary care to prevent a pressure wound developing**. If a service user has been given the wrong medication then an allegation of physical abuse is indicated in that the service user was given a non prescribed medication.

Try and be clear that at this stage, you are identifying the allegation not the reason or motivation of the alleged perpetrator. For example; an informal carer may have verbally abused a service user. Their motivation may well be that they are stressed but that doesn't change the impact of harm on the

service user. There is invariably a temptation to describe actions by formal carers as poor practice or a 'quality issue'. This does not sufficiently describe the impact on the service user. If the service user is harmed or at risk of being harmed then regardless of the motivation or reason for the action, it is abuse.

Making Safeguarding Personal (MSP)

MSP means the safeguarding enquiry should be person-centred and outcome-focused. It means having a conversation with the service user about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control, as well as improving quality of life, wellbeing and safety. At the beginning of the safeguarding enquiry you must ascertain the service user's views and wishes. What does the service user want to happen?

Any conversations that relate directly to the adult or to decisions involving them must always include them or their representative or advocate. The service user must be kept involved throughout the enquiry unless it would increase the risk of abuse or neglect.

Independent advocate

At the beginning of an enquiry, the local authority has a duty to consider whether the adult requires an independent advocate to represent and support them in the enquiry.

An independent advocate should be provided to an adult who would have 'substantial difficulty' in doing one or more of the following:

- understanding relevant information
- retaining that information
- using or weighing that information as part of the process
- communicating their views, wishes or feelings; and
- there is nobody else that is appropriate and able to represent them.

This should be kept under review as the enquiry progresses

Chronology/Contacts

You must record all of your actions in this section. They could be phone calls; meetings, visits, etc. Where you have collected or identified evidence you should record this in the following section, making reference to it in this section.

An example of this is as follows:

Chronology/Contact
6/06/2011 Reviewed care notes at residential care home (Paragraph 1; Evidence section)

Findings/Evidence
2. There was no evidence of an assessment on the care file provided etc

This section will contain all of the detail, in chronological order, of your networking and strategy discussions and meetings.

Networking (please refer to the relevant section in the procedures)

Once you have identified what allegation you are making an enquiry about, and wherever possible *who* you are investigating, you will need to identify what you know what you don't know, where you need to go to find the necessary information, etc (Refer to page 88 investigation cycle). Initially this will entail some clarification of the information on the referral; checking liquidlogic in relation to all significant people (e.g. alleged victim *and* alleged perpetrator) and for any previous safeguarding referrals, reviewing of social work files for background information, contact with quality assurance adult safeguarding unit for information from quality assurance systems etc. If you know the alleged victim lacks capacity, has difficulty being involved in the safeguarding enquiry and has no one suitable to support them you must make a referral for an independent advocate.

Strategy Discussions/Meetings (please refer to the relevant section in the procedures)

Every enquiry will need strategy discussions to decide on who will undertake the enquiry. For dentists, opticians and pharmacies you should consider NHS England. For NHS services (other than those mentioned above), you should consider Liverpool Clinical Commissioning Group (LCCG). The strategy discussion should include what the enquiry will cover, how it needs to be undertaken, etc. This discussion will include the manager allocating the

referral and all relevant or potential enquiry agencies e.g. police, LCCG, NHS England, commissioned providers, complaints team, etc. However, if there are a number of enquiries indicated, which may need to run concurrently, a formal strategy meeting will be required.

Findings/Evidence

These relate to the evidence you have gathered specifically with regard to the allegations you identified at the outset of the enquiry and the service user's desired outcomes. The findings will corroborate or refute the initial allegation(s). You should record anything you feel is significant to the enquiry in this section. This could be:

- direct evidence from the victim themselves, what they have experienced
- hearsay evidence or what a person has heard from another person
- circumstantial evidence, which may not be based on the facts in question but which supports the case, e.g. evidence of bruising immediately following a shift worked by a particular worker.

This evidence may take the form of documents you have reviewed, care notes, interviews you have conducted, photographs of injuries, etc.

Other findings

These are other findings that you discovered during the safeguarding enquiry. They will not be directly related to the initial allegation but will have raised concerns during your safeguarding enquiry. They may be general concerns about the way a service is being run, poor paperwork, it may be that you witnessed an incident during your enquiry that concerned you.

Conclusion(s)

Your conclusion(s) will be directly informed by your findings. Each allegation must have a conclusion and you must state why you have come to the relevant conclusion. In order to do this you will need to analyse the evidence you have gathered, decide on its relative strength and consider whether it corroborates or refutes the initial allegations.

There are *four* possible conclusions for each allegation you make enquiries into or cause others to do so. There should be one conclusions for the overall enquiry:

- ***Substantiated*** where evidence indicates that the abuse occurred as alleged
- ***Unsubstantiated*** where evidence indicates that the abuse did not occur as alleged or there is no evidence to support the allegation.
- ***Not determined/inconclusive*** where it is not possible to record an outcome against any other category, where suspicions remain but there is no clear evidence
- ***Partially substantiated*** where it has been possible to substantiate some but not all of the allegations (e.g. it was possible to substantiate an allegation of physical abuse but it was not possible to substantiate an allegation of financial abuse).

Service user outcomes

Has the service user's outcomes been achieved? e.g.

- the service user feels safer
- the service user has maintained key relationships
- the service user has received an apology/access to justice
- the service user knows how to protect themselves in the future.

It is always best to use the service user's own words

Feedback from service user

Please include any comments provided by the service user/their representative or advocate in relation to the safeguarding enquiry e.g. how they felt about the safeguarding enquiry, if they feel the enquiry has made a difference to them, were they satisfied with the outcome of the enquiry etc.

Recommendations

These must be reasonable and should identify who you think needs to take responsibility for following them up. For example, if a placement needs to be reviewed then the recommendation needs to indicate who you think needs to carry out that review. You may believe, having discussed this with contracts that a contract compliance visit is in order. You will need to identify why you feel a compliance visit is needed and that recommendation will need to be highlighted to the quality assurance and adult safeguarding team (those recommendations will be forwarded to quality assurance group and communicated to the corporate procurement team where appropriate).

Where you have made recommendations they need to be communicated with the relevant individuals/agencies that are being expected to follow them up. The information from your enquiry can only be shared on a need to know

basis. This means that you are unlikely to be sharing ALL of your safeguarding report with all agencies. Please refer to the relevant section in the procedures for a comprehensive explanation of information sharing. Please also refer to Caldicott Principles.

When deciding to share information with another agency you should make contact with the relevant person within the agency to inform them you will be sending information. You should consider removing personal identifying information when sending emails or hard copies of reports.

Where the enquiry relates to a regulated service the outcome of the safeguarding enquiry must be shared with CQC, whether or not CQC has been directly involved in the enquiry process. *('Our safeguarding Protocol: The Care Quality Commission's commitment to safeguarding')*

Appendix O Adult safeguarding enquiry officer checklist

Allocation of enquiry:
Complete initial risk assessment and planning with manager.
Interrogate data systems in relation to service user and alleged perpetrator.
Networking – relevant organisations contacted, consider who, when why.
Networking should enable you to make a decision on timings of any visits and any risks you have assessed.
If you think a crime may have been committed, you must make a referral to the Police. This should be done as early as possible in the enquiry process.
If networking indicates this is **not** a safeguarding enquiry, this needs to be clearly evidenced, agreed with manager and appropriate parties informed. Liquidlogic should be updated.
If a provider is implicated, do not contact them at this point.

Keeping the service user central to the process:
Establish the views and wishes of the service user; what do they want to happen.
Establish if there are any capacity issues in being involved. If the service user has substantial difficulty being involved in the safeguarding concern and there is no one suitable to support them, refer to an independent advocate.
Ensure service user is making a free and informed choice. Record any reasons why you are continuing with an enquiry, if it is against the service users wishes.
Consider if other people are at risk. Discuss with manager, regarding any actions to be taken.

The enquiry process:
You must discuss the allegation at the earliest opportunity with the service user or their representative or advocate to establish the service user's views and wishes. You must maintain contact throughout the enquiry.
Be clear about what the safeguarding issues are. Clarify the evidence you need to examine. Who can assist you with this, and then plan the order of your enquiry. **Consider calling a strategy meeting**.
Coordinate the input of other agencies/professionals as appropriate.
Provide a verbal report to your manager on how you intend to approach the enquiry. Ensure this is clearly documented.
Conduct appropriate interviews, ensuring information can be recorded for collating and evidential purposes.
Feedback to your line manager the outcome of your interviews/enquiry. Discuss the protection plans required for the service user. Ensure there is evidence for your conclusions.

Recommendations and safeguarding plans:
There should be a discussion with the service user at the end of enquiry to establish if the service user's outcomes have been achieved. The service user and their wishes should be central to the safeguarding plan.
Outcome report should clearly evidence findings from the enquiry and how conclusions have been reached and how the service user's outcomes have been achieved. Share this with your manager. **This must be signed before action on your recommendations.**
Where recommendations are made, these need to be clearly recorded, detailing what is required, by whom and by when. Share your recommendations with appropriate parties. You may need to call a multi-agency meeting to agreed actions.
A review for implementation of recommendations must be identified. Set clear timeframes. Be clear with your manager how these are going to be followed up to ensure safeguarding plan is implemented.

Closure of enquiry:
Inform relevant parties the enquiry is now closed. You need to consider how, with whom and what information you share regarding the outcome/closure of the safeguarding enquiry. You may need to call a multi-agency meeting or meet individuals' face-to-face depending on the case.
All relevant pages of liquidlogic must be completed to capture your enquiry.

Appendix P Acknowledgment letter, receipt of an adult safeguarding referral

Name of recipient
House number / name
Street name
City
Postcode

Date

Dear

Re: Contact with Careline

I am writing to acknowledge the receipt of your concerns raised with Careline.

In line with Liverpool's Safeguarding Adults Policy and Procedures this matter will be looked into.

When appropriate we can advise you of when the case is concluded, however, we may not be able to disclose all of the information gathered during the enquiry. This is in line with the Data Protection Act 1998.

I would thank you for bringing this matter to our attention and if you have any other information which could assist with our enquiry please do not hesitate to contact Careline again on 0151 233 3800.

Yours Sincerely

Social worker

Appendix Q Closure letter to referrer

Name of recipient
House number / name
Street name
City
Postcode

Date

Dear

Re: Safeguarding Enquiry

I can now confirm that the safeguarding enquiry has been completed in compliance with our safeguarding adults policy and procedure.

Please be aware that the local authority is governed by Data Protection and Information Sharing protocols in disclosing details of the enquiry.

I would like to take this opportunity to thank you for alerting us to this situation. If you have any concerns in the future please do not hesitate to Careline 0151 233 3800.

Social worker

Appendix R what happens if someone dies whilst subject to a Deprivation of Liberty Safeguards (DoLS) authorisation

Liverpool City Council

NHS Liverpool Clinical Commissioning Group

What happens if someone dies whilst?
subject to
a Deprivation of Liberty Safeguards (DoLS)
Authorisation

Community first

fighting crime
protecting communities

What happens if someone dies whilst subject to a deprivation of liberty safeguards (DoLS) authorisation?

Following guidance from the Chief Coroner for England and Wales, local coroners will be conducting a formal inquest for every person who dies whilst under a deprivation of liberty safeguards authorisation.

We understand that this is a very sensitive subject and could cause distress, however it is important you are made aware of these changes, and understand what these changes mean for you and your family.

The information below has been put together to help guide you through this process. If you have any further enquiries please contact the deprivation of liberty safeguards team or the coroner's office.

Process

Care homes
When a relative/friend in a care home subject to a deprivation of liberty safeguards authorisation dies, the care home will notify the police and the local coroner. The doctor who is called to confirm the death will not be able to issue a death certificate but will be asked to confirm the death has occurred.

Police
When a relative/friend on a deprivation of liberty safeguards authorisation dies, it is important that the deceased is not moved until the police are contacted. The room / location where the deceased person is found should be secured and a senior member of staff given the responsibility of securing the area until the police arrives.

When police are called, uniformed staff attend and conduct inquiries in respect of the circumstances of the death. Where there are no suspicious circumstances, the officers are required to complete a form No.97, which includes details of the deceased, next of kin and circumstances of their death. In addition, they may obtain copies of files, remove medication or other property. Staff and family members may also be spoken to and statements obtained from them. The report, including statements and form 97 are provided to the coroner at which point, the police involvement would usually cease, as responsibility is handed over to the coroner's department.

Coroner's office
The local coroner's office will make contact with family members/friends, the certifying doctor and the care home to establish facts about your relative's/friend's death and their care.

The local coroner will then make a decision as to whether a post mortem needs to be conducted. We know that this is part of the process that can upset people the most. However, a post mortem will only be conducted if the

cause of death is not known or there are circumstances around the death which give rise to concern.

The coroner will issue a fact of death certificate so that the burial/cremation can go ahead and this can be used to inform other agencies e.g. banks and building societies

The coroner will hold a subsequent inquest and family members will be approached to provide a witness statement should they wish to do so.

After the inquest is concluded the coroner will notify the register office, who will then register the death. You will not be required to attend the register office. The coroner will give you contact details for the register office if you wish to purchase death certificates after the death has been registered.

Will there be any delay to arranging a funeral?
This depends on the circumstances of your friend's/relative's death. The coroner's office need to make initial inquires and establish whether a post mortem is needed. However, they will do all that they can to ensure that there is as short a delay as possible.

Coroners are sensitive to the needs of particular faith groups and again will do all that they can to ensure things are moved along as quickly as possible.

How long will it take to hold the inquest and will this hold up the funeral?
This will depend on how busy the local coroner's court is at the time. Inquests can be held within days if a post mortem is not required. If further investigations are needed the inquest may be scheduled at a later date when court is available.
Funeral arrangements will not normally be held up by the timing of the inquest as the coroner will issue the necessary paperwork and a coroner's certificate of the fact of death which will allow the funeral to go ahead.

What do I do about registering my relative/friend's death at the register office?
The death cannot be registered until after the inquest has taken place. After the inquest is concluded the coroner will notify the register office, who will then register the death. You will not be required to attend the register office. The coroner will give you contact details for the register office if you wish to purchase death certificates after the death has been registered.

Contacts:

Liverpool Deprivation of Liberty Safeguards Team

Phone: 0151 233 0805
Email: deprivationoflibertysafeguards@liverpool.gov.uk

Liverpool and Wirral Coroner's Office

Opening times: Monday to Friday 8:30 to 16:15
Liverpool and Wirral Coroner Areas
Gerard Majella Courthouse
Boundary Street
Liverpool
L5 2QD

Tel: 0151 225 5770
Fax: 0151 207 4522
Email: coroner@liverpool.gov.uk

Liverpool Register Office

Opening times: Monday to Friday 9am-4.45pm and Saturday 9am-12 noon.
Liverpool Register Office
St George's Hall (Heritage Entrance)
St George's Place
Liverpool
L1 1JJ

Telephone: 0151 233 3004
Minicom: 0151 225 3275.

Appendix S Contacts

Domestic Violence Support Services

Independent Domestic Violence Adviser Service
0151 482 2499
0151 330 2014
0151 482 2496
0151 482 2484

Liverpool Domestic Abuse Service
0151 263 7474

South Liverpool Domestic Abuse Service
0151 494 1777

Amadudu
0151 734 0083

Adullum Housing - Grace House and FAE House
0151 708 4051

Women's Refuges

Amadudu
PO Box 252
Liverpool L69 8NA
Tel: 0151 734 0083
Fax: 0151 734 2840

Amadudu is a refuge for women with families who are experiencing domestic abuse. They specialise in provision for black women and women with black children. Support, advice, counselling and resettlement services are offered

Help Lines
National Domestic Violence helpline
Tel: 0808 2000 247

Appendix T Useful information

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

Care Act Statutory Guidance
https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

NHS England
http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf

Channel
https://www.gov.uk/government/publications/channel-guidance

Mental Capacity Act
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf

Domestic Violence National Helpline.
http://www.nationaldomesticviolencehelpline.org.uk/

CQC
http://www.cqc.org.uk/

SCIE
http://www.scie.org.uk/

Department of Health
https://www.gov.uk/government/organisations/department-of-health

Making safeguarding personal
http://www.local.gov.uk/documents/10180/5854661/Making+Safeguarding+Personal+-+Guide+2014/4213d016-2732-40d4-bbc0-d0d8639ef0df

Office of the Public Guardian
https://www.gov.uk/government/organisations/office-of-the-public-guardian

Appendix U Glossary

Terminology	Replace where relevant	Comments
Safeguarding concern	N/A	A safeguarding concern is when any person/organisation believes that an adult with care and support needs is experiencing or is at risk of abuse or neglect and that they are unable to protect themselves because of those needs and report their concerns to Careline and other relevant organisations e.g. police.
Section 42 of the Care Act 2014	'No secrets'	This is the section of the Care Act which describe the circumstances in which the local authority has a statutory duty to make enquiries or cause others to do so when an adult who: ● Has needs for care and support (whether or not the local authority is meeting any of those needs) and ● is experiencing, or is at risk of, abuse or neglect, and ● as a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect. NB. Unpaid carers are also covered by the procedures when they meet the above criteria.

Safeguarding enquiry /enquiry or section 42 enquiry	Investigation	The local authority must make or cause other agencies or organisations to make enquiries when Section 42 duty is triggered, i.e. when it has reasonable cause to believe that the three criteria in S42 of the Care Act have been met. There is a move away from investigations (except by the police and where disciplinary investigations are undertaken by employers).
Enquiry officer	Investigation officer	A suitably trained and skilled practitioner undertaking an enquiry or aspects of an enquiry.
Safeguarding adults review (SAR)	Serious case reviews	Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of, or has experienced serious abuse or neglect (known or suspected) and there is concern that partner agencies could have worked more effectively together. The aim of the SAR is to identify and implement learning from this.
Making Safeguarding Personal		'Making safeguarding personal' means it should be person-led and outcomes-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances

		involvement, choice and control as well as improving quality of life, wellbeing and safety.
Safeguarding plan	Protection plan	Actions / arrangements agreed with the adult to support them in maintaining their safety. It should include clear information regarding roles and responsibilities of all those involved and the arrangements for monitoring and reviewing the effectiveness of this plan.

Office of the
Public Guardian

Deputy standards

Public authority deputies

Supporting you and your decisions

gov.uk/opg

This document is available in large print, Welsh, audio and braille on request. Please call +44 (0)300 456 0300 or email customerservices@ publicguardian.gsi.gov.uk

Office of the Public Guardian
PO Box 16185
Birmingham
B2 2WH

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This document is also available from our website at gov.uk/opg

Ref: SD6

Introduction

These standards form an important part of our new, improved approach to supporting and supervising professional and public authority deputies.

The standards have been developed in partnership with both professional and public authority deputies and their representative bodies.

This collaborative approach has been a major factor in making sure that the standards support you in the important work you do.

The standards clearly set out what is expected of professional and public authority deputies and provide an important checklist of actions and behaviours every deputy should follow.

The standards fall into clear categories, allowing you to easily reference those appropriate to the management of your clients' affairs.

Standards one to four cover deputies acting under a property and affairs court order, while standards two to five are relevant to those with personal welfare orders. All five standards apply to deputies with orders covering both property and affairs and personal welfare.

Deputies will be assessed against the standards either through face-to-face assurance visits, assurance reviews conducted by telephone or during case reviews. Anyone selected for an assurance visit will be told in advance.

Where deputies are falling short, we can identify areas of weakness quickly and take the necessary steps with you to put things right. Where there are significant breaches of the standards, we will seek to agree an action plan with you to address deficiencies. In cases of the most serious or fundamental breaches we may seek removal of the deputy.

Most importantly, however, these standards will help you make sure your clients' best interests are served at all times.

Public authority deputy standards

Standard 1: Secure the client's finances and assets

1a: Benefits/assets/liabilities – when you receive a deputyship court order

Standards	Sources of evidence
1a (1) **Search for, identify and secure assets, savings and investments at the earliest opportunity.**	Records, letters and appointments attended with financial institutions and advisers. Inventory of assets and liabilities.
1a (2) **Notify banks and financial institutions, where the client is known to hold an account, of the court order.**	Records, letters and appointments attended with financial institutions and advisers.
1a (3) **Where there are other sources of income, for example, private pensions, notify the provider of the court order.**	Records, letters and appointments attended with financial institutions and advisers.
1a (4) **Identify, review and secure all benefits the client may be entitled to. Submit claims and lodge appeals at the earliest opportunity.**	Records, letters and appointments (if applicable) with DWP, use of specialist benefit software or consultation with benefits advisers.
1a (5) **Seek independent financial advice, where appropriate, to maximise the return on the client's savings, investments and any other assets.**	Record of financial advice received and subsequent investments made.
1a (6) **Seek recovery of any money or assets owed to the client, by way of debts and/or loans, for example rent from lettings or utility accounts in credit.**	Record of letters to and from organisations or individuals. Inventory of assets and liabilities, for example, utility companies, banks, loan companies.

Standards	Sources of evidence
1a (7) **Ensure scrutiny of, and where appropriate payment of, any liabilities by the client, for example utility bills and care home bills.**	Record of letters to and from organisations or individuals. Inventory of assets and liabilities, for example, utility companies, banks, loan companies.
1a (8) **Where public authority care is being provided, ensure that a financial assessment has been progressed and that charges are accurate and based on up-to-date financial information.**	Completed financial assessment forms, record of assessments, payment record, OPG 102.
1a (9) **Open a deputyship account in the client's name with the deputy named as such on the account. Ensure that all funds held for the client are held in accounts and/or investments in their name and kept separate from the funds of the deputy or other parties.**	Copies of financial records and statements showing funds are held in accounts in the client's name. Record of letters and conversations with financial institutions showing requests for the opening of deputyship accounts.

1b: Benefits/assets/liabilities – ongoing

1b (1) **Carry out benefit and public authority funding reviews at least once a year, ensuring any changes in the client's assets are reported promptly.**	Record of benefit and public authority funding reviews, contact with DWP and date of last review.
1b (2) **Ensure that staff hold appropriate skills and knowledge of benefits through regular training and updates (including criteria for eligibility and how to apply).**	Training plan, skills matrix, relevant contacts available. Use of specialist benefits software or outsourcing.
1b (3) **Carry out reviews of savings and investment portfolios at least once a year. Seek expert and independent advice when necessary.**	Record of letters to and from investment advisers and date of last review.
1b (4) **Demonstrate responsible use of assets, rather than asset preservation.**	Records and evidence of decision making.

1c: The client's property (if they don't live there) – when you receive a deputyship court order

Standards	Sources of evidence
1c (1) Determine the ownership entry recorded at HM Land Registry, for example, sole ownership, joint tenants, or tenants in common.	Records or letters from HM Land Registry showing property details.
1c (2) Where there is no other living owner able to do so, gain access to the property and carry out a visit to ensure it is secure.	Record to show when this was carried out, who carried it out and who was consulted before entry (for example, the client). Receipts for any costs incurred.
1c (3) Complete an inventory of contents. Consider what the property and its contents say about the client. This includes likes, dislikes, interests and family photos.	Inventory of property contents and value. Audit trail of items removed from the property and their location. If items are auctioned or sold, clear records of their disposal.
1c (4) Consider whether it is appropriate for items of sentimental value to be provided for the client where they now reside. For example, clothes, sentimental items, DVDs, CDs.	Record of best interest decisions made and family members or people consulted. Audit trail of items removed from the property and their location.
1c (5) Ensure appropriate buildings and contents insurance are in place and familiarise yourself with the terms of the policy.	Record of valid insurance such as the insurance policy or insurance certificate. Inventory of property contents and value.
1c (6) Get post redirected and maintain ongoing provision of utilities, if applicable.	Record of letters to and from Royal Mail and utility companies.
1c (7) If the property is owned by the client, liaise with the client, any joint owners and/or the client's family, where appropriate, to decide the best course of action. Act accordingly – for example sell, let or maintain.	Record of best interest decisions made and family members/people consulted. Evidence that you are following the court order.

Standards	Sources of evidence
1c (8) **If the client is in public authority funded care, give consideration to a deferred payment arrangement.**	Record of best interest decision.
1c (9) **If the client's property is let, ensure that notice is given to terminate the tenancy, where appropriate, and in good time.**	Record of best interest decisions made and letters to and from the tenant.
1c (10) **Consider pre-existing arrangements of any family residing in the client's property and whether it may be appropriate for regular payments to be made to or from the client.**	Record of best interest decisions made and family members/people consulted. Record of letters to and from the tenant. Evidence of pre-existing agreements with the client and tenants.

1d: The client's property (if they don't live there) – ongoing

1d (1) **Ensure that the property is secured and maintained appropriately.**	Record of letters and expenditure. Record of regular property inspection visits.
1d (2) **If let, ensure the correct legal tenancy agreement(s) are in place and maintained. Consider seeking specialist property law advice if required.**	Copy of tenancy agreement.
1d (3) **If let, take reasonable steps to ensure that tenants maintain the property in good order and take appropriate action if they are in breach of the tenancy agreement.**	Record of visits to the property and any discussions held with the tenants in line with the tenancy agreements.
1d (4) **Undertake regular reviews of the client's needs and undertake an evaluation of the decision to let or sell as appropriate.**	Record of property reviews and best interest decisions made. Valuation quotes from estate agents.
1d (5) **If selling the property, prepare the property for sale, engaging an agent and obtaining a minimum of three separate valuations.**	Record of decision on asking price. Record of offers considered.

Standards	Sources of evidence
1d (6) **Ensure appropriate buildings and contents insurance are in place and familiarise yourself with the terms of the policy.**	Record of valid insurance such as the insurance policy or insurance certificate. Inventory of property contents and value.
1d (7) **If let, ensure gas check certificates are obtained for gas fires, boilers and appliances.**	Record of relevant certificates.

1e: The client's property (if they live there) – when you receive the deputyship order

1e (1) **Review the client's needs and the suitability of the property.**	Visitor's report. Evidence of people consulted and action(s) taken where improvements have been identified.
1e (2) **Review any tenancy or mortgage agreements, securing any deeds of ownership.**	Copies of any tenancy or mortgage agreements.
1e (3) **Ensure appropriate buildings and contents insurance are in place and familiarise yourself with the terms of the policy.**	Record of valid insurance such as the insurance policy or insurance certificate.
1e (4) **Ensure gas check certificates are obtained for gas fires, boilers and appliances.**	Record of relevant certificates.
1e (5) **Review or commission a care plan or occupational therapy report and commission any aids/adaptations necessary to ensure that the client's needs are met.**	Record of best interest decisions made and family members/people consulted. Care plan, occupational therapist's report.
1e (6) **If the client is responsible for household bills, agree any contributions to be made from, or to, other household members where necessary.**	Record detailing client's contribution, utility bills, record of best interest decisions made and people consulted.

1f: The client's property (if they live there) – ongoing

Standards	Sources of evidence
1f (1) Regularly review the condition of the property and ensure it is adequately maintained.	Record of visit and survey of property.
1f (2) Regularly review the suitability of the property for the client and commission updated care plans.	Record of people consulted and best interest decisions made.
1f (3) Regularly review arrangements with other occupiers.	Record of people consulted and best interest decisions made.

1g: Care arrangements – when you receive the deputyship court order

1g (1) Contact the care providers, tell them of your appointment as deputy and provide your contact details.	Record of contact to and from care providers.
1g (2) Ensure any level of care (including any supplementary therapies or treatments) is relevant to the client, good value for money and appropriate to the level of funds available.	Record of best interest decisions made and people consulted. Care plans and records of regular reviews.
1g (3) Arrange for the client to receive a personal allowance, relevant to their needs.	Record of personal allowance being paid, for example, a bank statement or ledger.

1h: Care arrangements – ongoing

1h (1) Arrange for the client to receive a personal allowance, relevant to their needs.	Record of care reviews, any recommendations made and changes to be implemented.

Standard 2: Gain insight into the client to make decisions in their best interests

Standards	Sources of evidence
2 (1) **Ensure capacity assessments in respect of specific decisions have been carried out when receiving the case and as future decisions are required.**	Copies of capacity assessments. Record of ongoing reviews.
2 (2) **Maintain records of decisions made, including gifting, who was consulted and the reasons for any decisions.**	Decision checklist. Record of family members/people consulted and best interest decisions made.
2 (3) **Discuss and record the client's feelings, wishes, beliefs and interests, both past and present, with the client, their family and care providers.**	Records including correspondence, phone calls, minutes and case notes.
2 (4) **As appropriate, discuss any decisions to be taken with the client's family and care providers according to the client's wishes.**	Records including correspondence, phone calls, minutes and case notes.
2 (5) **Maintain regular contact with the client/carers/family members and conduct visits to the client at least once a year.**	Record of contact/visits, any recommendations and follow up action taken.
2 (6) **Carry out regular reviews of the client's needs, expenditure and their capacity to handle money. For example do they receive benefits or a weekly cash allowance?**	Record of capacity assessments, best interest decision making.

Standards	Sources of evidence
2 (7) **Actively demonstrate protection of the client from exploitation of financial abuse (for example, through registration with credit protection agency).**	Record of correspondence with financial institutions.
2 (8) **Use appropriate ways to communicate with the client, for example, in his or her preferred language.**	Record of services used to improve communication with client and any associated invoices.

Standard 3: Maintain effective internal office processes and organisation

3a: Governance

Standards	Sources of evidence
3a (1) **Establish clear and effective governance between the named deputy and staff delegated to carry out the day-to-day functions of the role.**	Clear and organised files, attendance notes. Clearly defined roles and processes in place so staff know who to report to and when. Compliance controls in place.
3a (2) **Maintain a clear record of all staff delegated the authority to carry out tasks by the deputy, including a list of signatories.**	Record of all staff members.
3a (3) **Demonstrate sufficient senior internal supervision of the overall deputyship process.**	Documented policies and procedures, clear team structures in place.
3a (4) **Where a level of decision making is delegated, ensure the criteria for decision making requiring the sanction of the deputy are clearly defined and understood.**	Compliance controls and an audit trail.
3a (5) **Ensure documented agreements and of accountability are in place for any duties performed by staff outside the public authority (that is, outsourced). Carry out appropriate oversight and monitoring and clearly show that the named deputy remains fully accountable for decisions taken in respect of clients.**	Documentation showing that the named deputy remains fully accountable for decisions taken in respect of clients.

Standards	Sources of evidence
3a (6) **Ensure that all necessary financial, security, management, organisational and quality control systems are in place with regard to:** • **accounting systems** • **controls over cash handling, banking and access to bank accounts** • **separation of clients' funds** • **IT security and information assurance**	Records on staff with access to sensitive client information, including employment contract, checks for previous convictions for fraud, criminal record checks. Record of enhanced checks for those who have direct contact with the client. Record of induction training, ongoing training and Continuing Professional Development. Record of written policies. Bills or invoices with appropriate narrative/ itemisation to account to the client, where appropriate, regarding their finances and your charges.
3a (7) **Maintain clear polices on:** • **data protection** • **business continuity** • **banking and money handling.**	Internal policies, procedures and training records specific to work under a Court of Protection deputyship order.
3a (8) **Maintain confidentiality on individual client matters.**	Records on staff with access to sensitive client information, including employment contract, checks for previous convictions for fraud, criminal record checks. Record of enhanced checks for those who have direct contact with the client. Record of induction training, ongoing training and Continuing Professional Development. Clear information assurance policies and procedures in place. Secure filing/electronic case records.
3a (9) **Keep client records up to date by regularly reviewing and recording the client's capacity, capability and support they need.**	Record of client profiles. Clear safeguarding systems in place, audit trail.
3a (10) **Carry out regular billing of deputy's costs in line with the fixed costs practice direction.**	Financial records and deputy report.

Standards	Sources of evidence
3a (11) **Review the ratio of staff to cases.**	Show ongoing review of the ratio of staff to cases to ensure deputy's obligations are met.
3a (12) **Document referral criteria for deputyships widely disseminated this to social care staff within the public authority.**	Records and documentation on referrals.
3a (13) **Ensure accounting and audit processes are in place within the public authority.**	Record of audits.

3b: Office culture and customer service

Standards	Sources of evidence
3b (1) **Ensure that opportunities exist for members of staff to hold case discussions with peers or senior supervisor/manager.**	Record of best interest decisions, who's been consulted, minutes, case notes.
3b (2) **Ensure there is adequate cover during holiday/absence periods.**	Records on office whereabouts, appropriate planning for staff absences and business continuity plans.
3b (3) **Ensure access to the services of translators and interpreters, where necessary.**	Record of relevant contact details, information packs.
3b (4) **Have access to specialist advice, for example, a financial accountant, either internally or externally.**	Record of advice sought/provided and by whom.
3b (5) **Ensure that all parties have access to a copy of the documented complaints handling procedure and the options for resolving disputes.**	Record of relevant contact details, information packs.
3b (6) **Ensure that all decisions taken are free from any conflict of interest, be it personal or organisational.**	Records of conflict of interest and decision making and any declarations.
3b (7) **Ensure that the deputy's or case supervisor's contact details are provided to all relevant parties.**	Record of general correspondence.

3c: Safeguarding

3c (1) **Ensure all staff are aware of procedures to follow in handling safeguarding issues. The deputy should know how to make a referral to the relevant authority.**	Record of referrals made. Record of training attended. Office policy documents.

Standard 4: Have the skills and knowledge to carry out the duties of a deputy

Standards	Sources of evidence
4 (1) **Ensure the deputy and all members of staff delegated with deputyship responsibilities understand the Mental Capacity Act (MCA) and its Code of Practice.**	Record of training attended, Continuing Professional Development points, reference material used. Affiliation to relevant organisations such as the Association of Public Authority Deputies (APAD). Client records that demonstrate systematic application of the principles of the MCA.
4 (2) **Ensure the deputy and all members of staff delegated with deputyship responsibilities understand how the five statutory principles of the MCA are applied within their working practices.**	Case specific example of how each of the five statutory principles have been applied.
4 (3) **Ensure the deputy and all members of staff delegated with deputyship responsibilities understand Court of Protection practice and procedures.**	Record of training plans, skills matrix for all staff members.
4 (4) **Ensure the deputy and all members of staff delegated with deputyship responsibilities know about the role of the Public Guardian and his role in supervising deputies.**	Record of training plans, skills matrix for all staff members. OPG records.

Standards	Sources of evidence
4 (5) **Ensure the deputy and all members of staff delegated with deputyship responsibilities know how to get appropriate advice and expertise on Social Security benefits, including eligibility criteria.**	Record of relevant contact details, information packs. Record of advice sought/provided.
4 (6) **Ensure the deputy and all members of staff delegated with deputyship responsibilities know how to access appropriate advice and expertise on NHS Free Nursing Care and Continuing Health Care funding or funding under section 117 of the Mental Health Act 1983.**	Record of relevant contact details, information packs. Record of advice sought/provided.
4 (7) **Ensure the deputy and all members of staff delegated with deputyship responsibilities know about public authority funding and charges for care, and how to access appropriate advice and expertise.**	Record of relevant contact details, information packs. Record of training plans, skills matrix for staff members.
4 (8) **Ensure the deputy and all members of staff delegated with deputyship responsibilities know about promoting the ongoing allocation of a care professional when the client doesn't have any family, carer or friend who could speak on their behalf.**	File records, record of relevant contact details.
4 (9) **Ensure the deputy and all members of staff delegated with deputyship responsibilities have access to appropriate advice and expertise on investments, savings and property.**	Record of relevant contact details, information packs. Record of advice sought/provided.
4 (10) **Ensure the deputy and all members of staff delegated with deputyship responsibilities have access to appropriate advice and expertise on inheritance tax planning and trusts, including how to apply for a statutory will.**	Record of relevant contact details, information packs. Record of advice sought/provided.

Standards	Sources of evidence
4 (11) **Ensure the deputy and all members of staff delegated with deputyship responsibilities have access to appropriate advice and expertise on personal tax returns.**	Record of relevant contact details, information packs. Record of advice sought/provided.
4 (12) **Ensure the deputy and all members of staff delegated with deputyship responsibilities have awareness or experience in managing family conflict/mediation.**	Access to mediation services.

Standard 5: Health and Welfare Standards

(for deputies who hold a personal welfare court order only, and deputies who hold both a personal welfare court order and a property and affairs court order)

Standards	Sources of evidence
5 (1) **Adhere to the personal welfare court order and its limitations under the Mental Capacity Act – for example, when deciding where the client should live. If self funding the deputy can choose any accommodation they wish as long as it meets the client's needs. If the client is not self funding, the deputy must work alongside the funding provider and come to a mutual agreement in the best interests of the client.**	Records, letters and appointments attended with care providers, Social Services, the public authority, family and friends. Record of best interest decisions made and people consulted, care plans and regular reviews.
5 (2) **If carers are employed, ensure appropriate Discolure Barring Service (DBS) checks are in place and that the number of carers meets the client's needs.**	Record of DBS checks carried out on staff working with client seen by the deputy. Record of best interest decisions made and people consulted, care plans and regular reviews.
5 (3) **If a Deprivation of Liberty (DoL) order exists for the client, the deputy must ensure it is relevant and current.**	Records to show that discussion has taken place with the person responsible for applying to put the DoL in place – for example, the care home manager.
5 (4) **Carry out a health review/ assessment at least once a year to ensure the clients needs have not changed and are still being met.**	Records, letters and/or appointments to show that the health review/assessment has taken place.

Standards	Sources of evidence
5 (5) **Deputies should be aware of the Care Act, where wellbeing is paramount, and act accordingly.**	Awareness of the new Act and accessing it via www.gov.uk for further clarification or information.
5 (6) **Notify all involved in the client's network, such as clinicians, care provider and other professionals, and send copies of the court order.**	Records, letters and appointments attended with financial institutions and advisers.