NORTH LINCOLNSHIRE
SAFEGUARDING ADULTS BOARD

Safeguarding Adults Policy and Procedures 2015-2017

Foreword

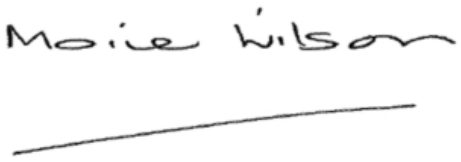
Welcome to the revised Safeguarding Adults Policy and Procedure which reflect not only the development of practice since the publication of No Secrets but the duties and principles enshrined in the Care Act 2014.

At the heart of our Policy and Procedures are the principles of Making Safeguarding Personal which places peoples` experiences and outcomes at the centre of all safeguarding in a way that enhances Involvement, Choice and Control. This principle is therefore at the core of all of the North Lincolnshire Safeguarding Adults Board activity.

In North Lincolnshire we already have well established and robust multi - agency arrangements for safeguarding adults. The key purpose of these Procedures is to continue to develop and enhance this work in order to secure a coordinated and integrated approach that identifies and responds effectively to any issues of neglect or harm.

As the legislation and guidance from the government on Adult Safeguarding is new these Policy and Procedures should be seen as documents which will be developed and amended over future months and as any legislative changes are made.

We hope you find these policies and procedures helpful in working together to safeguard in North Lincolnshire. We would like you to share these widely with front line practitioners, partners and the wider public.



Moira Wilson
Independent Chair
North Lincolnshire Safeguarding Adults Board

Introduction

This Safeguarding Adults Policy and Procedures document is a multi-agency document endorsed by the North Lincolnshire Safeguarding Adults Board.

Chapters 1 - 3 cover the agreed local policy, key agency roles and responsibilities and essential information relating to the North Lincolnshire Safeguarding Adults Board.

Chapter 4 provides staff from all agencies involved with the Safeguarding Adults process an overview of the agreed procedures and pathways relating to safeguarding adults in order to ensure a consistent approach when allegations of abuse are investigated.

A detailed appendix is attached with hyperlinks to core safeguarding documentation, further policies and other key information.

This document updates and supersedes the North Lincolnshire Safeguarding Adults Procedures published in 2014 and is based on the guidance contained within 'The Care Act 2014' and sets out the policy principles and core process for Safeguarding Adults. Previous references to the 'Protection of Care and support needs Adults' and to 'Adult Protection' work will be replaced by the new term 'Safeguarding Adults'.

Although the accountability for the coordination of safeguarding adult's arrangements rests with councils with social services responsibilities, (CSSR) the operation of procedures is a joint initiative. This policy and procedures has therefore been agreed and endorsed at a senior and executive level by all partner agencies at the North Lincolnshire Safeguarding Adults Board.

It confirms the high priority given to Safeguarding Adults, in that partners agree to:

- Protect an adult's right to live safely, free from abuse and neglect
- Always promote the adults well-being in their safeguarding arrangement
- Support staff and volunteers who raise concerns
- Commit to providing training and development opportunities for all staff to support them in their safeguarding responsibilities, as outlined in the interagency procedures.

This document and all appendices are published on the North Lincolnshire Council website, Safeguarding Adults pages.

Section A

North Lincolnshire Safeguarding Adults Policy

Chapter 1

Policy Statement

The following policy has been written to meet the needs of all professionals and adults with care and support needs within North Lincolnshire. It has been compiled following collaboration with other Safeguarding professionals within the region.

1. The Duty to Safeguard Adults

The Safeguarding duties apply to 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 at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

The adult experiencing, or at risk of abuse or neglect will hereafter be referred to as the adult throughout this chapter.

The safeguarding duties have a legal effect in relation to the three essential organisations which are North Lincolnshire Council People Directorate, North Lincolnshire Clinical Commissioning Group and Humberside Police.

Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25. Where appropriate, adult safeguarding services should involve the local authority's children's safeguarding colleagues as well as any relevant partners (e.g. the Police or NHS) or other persons relevant to the case. However, the level of needs is not relevant, and the young adult does not need to have eligible needs for care and support under the Care Act, or be receiving any particular service from the local authority, in order for the safeguarding duties to apply – so long as the conditions set out are met.

Statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult

lacks capacity or not, and regardless of setting, other than prisons and approved premises where prison governors and National Offender Management Service (NOMS) respectively have responsibility. However, senior representatives of those services may sit on the Safeguarding Adults Board and play an important role in the strategic development of adult safeguarding locally. Additionally, they may ask for advice from the local authority when faced with a safeguarding issue that they are finding particularly challenging.

2. Adult Safeguarding – what it is and why it matters

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

Organisations should always promote the adult's wellbeing in their safeguarding arrangements. People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating "safety" measures that do not take account of individual well-being, as defined in Section 1 of the Care Act.

Safeguarding is not a substitute for:

- Providers' responsibilities to provide safe and high quality care and support;
- Commissioners regularly assuring themselves of the safety and effectiveness of commissioned services;
- The Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action; and
- The core duties of the police to prevent and detect crime and protect life and property.

The Care 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 their turn each relevant partner must also co-operate with the local authority.

The aims of adult safeguarding are to:

- Stop abuse or neglect wherever possible
- Prevent harm and reduce the risk or abuse or neglect to adults with care and support needs;
- Safeguard adults in a way that supports them in making choices and having control about how they want to live;
- Promote an approach that concentrates on improving life for the adults concerned;
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to 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 well-being of an adult; and
- Address what has caused the abuse or neglect

In order to achieve these aims, it is necessary to:

- Ensure that everyone, both individuals and organisations, are clear about their roles and responsibilities;
- Create strong multi-agency partnerships that provide timely and effective prevention of and responses to abuse or neglect;
- Support the development of a positive learning environment across these partnerships and at all levels within them to help break down cultures that are risk-averse and seek to scapegoat or blame practitioners;
- Enable access to mainstream community resources such as accessible leisure facilities, safe town centres and community groups that can reduce the social and physical isolation which in itself may increase the risk of abuse or neglect; and
- Clarify how responses to safeguarding concerns deriving from the poor quality and inadequacy of service provision, including patient safety in the health sector, should be responded to.

The following six principles apply to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider local authority functions and the criminal justice system. The principles should inform the ways in which professionals and other staff work with adults. The principles can also help SABs, and organisations more widely, by using them to examine and improve their local arrangements.

Six key principles underpin all adult safeguarding work

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

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

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

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

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

- **Accountability –** Accountability and transparency in delivering safeguarding
  "I understand the role of everyone involved in my life and so do they."

(Care Act Department of Health, 2014)

3. Shared Governing Principles of safeguarding adults with care and support needs

In order to safeguard and promote the welfare of adults with care and support needs, every organisation represented at the North Lincolnshire Safeguarding Adults Board should follow and take into account the key principles, values and good practice guidelines leading to an effective safeguarding system when carrying out its usual functions. These are;

3.1 All individuals have a right to:

- The protection of the law and to live their lives free from violence, abuse and risk
- Be listened to and what they have to say is taken seriously and acted upon in an appropriate manner.
- Privacy
- Be treated with dignity
- Lead an independent life and be enabled to do so
- Be able to exercise choice about how they lead their lives
- Independent support and representation, particularly where there is an issue about mental capacity
- Have their rights upheld regardless of ethnic origin, gender, sexuality, disability, age, religious or cultural background and beliefs
- To make informed decisions, including the taking of risks and to have maximum control over their own lives wherever possible

3.2 The needs of the individual who is being abused or is suspected of being abused or is at significant risk will always be of paramount concern. Work with each care and support needs adult and family focuses on improving the well-being and life chances of that individual and family; care and support needs adults are listened to and what they have to say is taken seriously and acted on in an appropriate manner. The wishes and feelings of the care and support needs adult must be taken into account. Communication with the adult will be according to their needs e.g. another language, signing.

3.3 A person is not to be treated as unable to make a decision just because they make an unwise decision. A person must be assumed to have capacity unless it is established that they lack capacity in accordance with the Mental Capacity Act Code of Practice 2005. A person is not to be treated as unable to make a decision unless all practicable (achievable) steps to help them to do so have been taken without success.

3.4 Any act done or decision made, for or on behalf of a person who lacks capacity must be done, or made, in their best interests. Any act done or decision made, for or on behalf of a person who lacks capacity should be achieved in a way that is less restrictive of the person's rights and freedom of action.

3.5 Intervention should be proportionate to the harm, or real possibility of future harm, and which has the overall effect (outcome) of improving the life of the adult, including their safety and happiness.

3.6 Assessments of adults with care and support needs and families are consistent with current best practice and interventions should take place at an early point when difficulties or problems are identified.

3.7 Race, gender, sexuality, culture, language, faith and disability are taken into account when working with a care and support needs adult and their family.

3.8 People experiencing abuse and their representatives should be made aware of their rights to take action on their own behalf, for example in contacting the Humberside Police, or speaking directly to the Care Quality Commission, obtaining their own legal advice, or using complaints procedures.

3.9 Relevant services should be provided to respond to the identified needs of care and support needs adults and to support carers in effectively undertaking their roles. This may require referral to a colleague within the agency or to another agency to obtain advice, guidance and/or appropriate services. Where a particular service is not available or there is a delay in it being available, alternative services should be provided where possible to ensure the care and support needs adult's welfare is safeguarded.

3.10 Where a number of professionals are involved in supporting a care and support needs adult and their family, a co- ordinated approach to meeting their needs should be developed. In these cases, it may be appropriate for one practitioner among those involved to take on a lead role in co-ordinating the support.

3.11 Each stage of the safeguarding process should consider an outcome which supports or offers the opportunity to develop or to maintain, a private life which includes those people with whom the adult wishes to establish, develop or continue a relationship and a right to make an informed choice.

3.12 All staff have a responsibility to report any and all concerns regarding abuse, suspected abuse or significant risk. All staff have the right to expect that their concerns are acted upon and treated seriously without fear of reprisals. Their anonymity will be protected as far as possible. A culture of intolerance to all abuse should be encouraged through staff training, cultural awareness and regular effective supervision and monitoring of work with individual care and support needs adults and their families.

3.13 Quality records will be kept and information appropriately shared on all work with individual care and support needs adults and their families in accordance with agency requirements and agreements.

3.14 All agencies developing their own procedures will use the agreed definitions and exhibit zero tolerance to abuse. The roles specified in procedures should be clear about which incidents will not require investigation under the multi-agency policy and comply with current regulations.

4 Making Safeguarding Personal

In addition to these shared governing principles, it is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances and life-styles, so it is helpful to prescribe a process that must be followed whenever a concern is raised.

Making safeguarding personal means it should be person-led and outcome-focussed. 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.

5 What are abuse and neglect?

"Abuse" is a violation of an individual's human and civil rights by any other person or persons and takes many forms.

An accepted definition of significant harm is: 'ill-treatment (including sexual abuse and forms of ill treatment that are not physical); the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, emotional, social or behavioural development'. (Law Commission 1995)

This section considers the different types and patterns of abuse and neglect and the different circumstances in which they may take place. This is not intended to be an exhaustive list but an illustrative guide as to the sort of behaviour which could give rise to a safeguarding concern.

- **Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.
- **Domestic violence** – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.
- **Sexual abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.
- **Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal or services or supportive networks.
- **Financial or material abuse** – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
- **Modern slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at

their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
- **Discriminatory abuse** – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.
- **Organisational abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.
- **Neglect and acts of omission** – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of necessities of life, such as medication, adequate nutrition and heating.
- **Self-neglect** – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents or individuals to identify patterns of harm, just as the Care Quality Commission, as the regulator of service quality, does when it looks at the quality of care in health and care services. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. In order to see these patterns it is important that information is recorded and appropriately shared.

Who abuses and neglects adults?

Anyone can carry out abuse or neglect, including:

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

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

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

Spotting signs of abuse and neglect

Workers across a wide range of organisations need to be vigilant about adult safeguarding concerns in all walks of life including, amongst others in health and social care, welfare, policing, banking, fire and rescue services and trading standards; leisure services, faith groups, and housing. GPs, in particular, are often well-placed to notice changes in an adult that may indicate they are being abused or neglected. Findings from Safeguarding Adult Reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, then death or serious harm might have been prevented.

Anyone can witness or become aware of information suggesting that abuse and neglect is occurring. The matter may, for example, be raised by a worried neighbour, a concerned bank cashier, a GP, a welfare benefits officer, a housing support worker or a nurse on a ward. Primary care staff may be particularly well-placed to spot abuse and neglect, as in many cases they may be the only professionals with whom the adult has contact. The adult may say or do things that hint that all is not well. It may come in the form of a complaint, a call for a police response, an expression of concern, or come to light during a needs assessment. Regardless of how the safeguarding concern is identified, everyone should understand what to do, and where to go locally to get help and advice. It is vital that professionals, other staff and members of the public are vigilant on behalf of those unable to protect themselves. This will include:

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

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

6 Categories and Indicators of abuse

6.1 Physical Abuse

Physical injuries which have no satisfactory explanation or where there is a definite knowledge, or a reasonable suspicion that the injury was inflicted with intent, or through lack of care, by the person having custody, charge or care of that person, including hitting, slapping, pushing, misuse of or lack of medication, restraint, or inappropriate sanctions.

Possible Indicators of physical abuse:

- History of unexplained falls or minor injuries

- Unexplained bruising – in well protected areas, on the soft parts of the body or clustered as from repeated striking
- Unexplained burns in an unusual location or of an unusual type
- Unexplained fractures to any part of the body that may be at various stages in the healing process
- Unexplained lacerations or abrasions
- Slap, kick, pinch or finger marks
- Injuries/bruises found at different stages of healing for which it is difficult to suggest an accidental cause
- Injury shape similar to an object
- Untreated medical problems
- Weight loss – due to malnutrition or dehydration; complaints of hunger
- Appearing to be over medicated

6.2 Psychological Abuse

Psychological, or emotional abuse, includes the use of threats, fears or bribes to negate a care and support needs adult's choices, independent wishes and self-esteem; cause isolation or overdependence (as might be signalled by impairment of development or performance); or prevent a care and support needs adult from using services, which would provide help.

Possible Indicators of psychological abuse:

- Ambivalence about carer
- Fearfulness expressed in the eyes; avoids looking at the carer, flinching on approach
- Deference
- Overtly affectionate behaviour to alleged source of risk
- Insomnia/sleep deprivation or need for excessive sleep
- Change in appetite
- Unusual weight gain/loss
- Tearfulness
- Unexplained paranoia
- Low self-esteem
- Excessive fears
- Confusion
- Agitation

6.3 Sexual Abuse

Sexual acts which might be abusive include non-contact abuse such as looking, pornographic photography, indecent exposure, harassment, unwanted teasing or innuendo, or contact such as touching breasts, genitals, or anus, masturbation, penetration or attempted penetration of vagina, anus, and mouth with or by penis, fingers or other objects (rape).

Possible Indicators of sexual abuse:

- A change in usual behaviour for no apparent or obvious reason
- Sudden onset of confusion, wetting or soiling
- Withdrawal, choosing to spend the majority of time alone
- Overt sexual behaviour/language by the care and support needs person
- Disturbed sleep pattern and poor concentration
- Difficulty in walking or sitting
- Torn, stained, bloody underclothes
- Love bites
- Pain or itching, bruising or bleeding in the genital area
- Sexually transmitted urinary tract/vaginal infections
- Bruising to the thighs and upper arms
- Frequent infections
- Severe upset or agitation when being bathed/dressed/undressed/medically examined
- Pregnancy in a person not able to consent

6.4 Domestic Abuse

In 2013, the Home Office announced changes to the definition of domestic abuse:

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse by someone who is or has been an intimate partner or family member regardless or gender or sexuality
- Includes: psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence; Female Genital Mutilation; forced marriage
- Age range extended down to 16 or over

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work (that meets criteria) that occurs at home is, in fact concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

6.5 Financial Abuse

Financial abuse is the main form of abuse investigated by the Office of the Public Guardian amongst adults at risk. Financial recorded abuse can lead to isolation, but research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Although this is not always the case, everyone should also be aware of this possibility.

This usually involves an individual’s funds or resources being inappropriately used by a third person (i.e. theft) It includes the withholding of money or the inappropriate or unsanctioned use of a person’s money or property or the entry of the care and support needs adult into financial contracts or transactions that they do not understand, to their disadvantage.

Possible Indicators of financial abuse

Potential indicators of financial abuse include:

- Change in living conditions
- Lack of heating, clothing or food;
- Inability to pay bills/unexplained shortage of money;
- Unexplained withdrawals from an account;
- Unexplained loss/misplacement of financial documents;
- The recent addition of authorised signers on a client or donor's signature card; or
- Sudden or unexpected changes in a will or other financial documents.
- Unexplained or sudden inability to pay bills
- Unexplained or sudden withdrawal of money from accounts
- Person lacks belongings or services, which they can clearly afford
- Lack of receptiveness to any necessary assistance requiring expenditure, when finances are not a problem – although the natural thriftiness of some people should be borne in mind
- Extraordinary interest by family members and other people in the care and support needs person's assets
- Power of Attorney obtained when the care and support needs adult is not able to understand the purpose of the document they are signing
- Recent change of deeds or title of property
- Unpaid carer or support worker only asks questions of the worker about the user's financial affairs and does not appear to be concerned about the physical or emotional care of the person
- The person who manages the financial affairs is evasive or uncooperative
- A reluctance or refusal to take up care assessed as being needed
- A high level of expenditure without evidence of the person benefiting
- The purchase of items which the person does not require or use
- Personal items going missing from the home
- Unreasonable and /or inappropriate gifts

6.6 Neglect / Acts of Omission

Neglect can be both physical and emotional. It is about the failure to keep a care and support needs adult clean, warm and promote optimum health, or to provide adequate nutrition, medication, being prevented from making choices. Neglect of a duty of care or the breakdown of a care package may also give rise to safeguarding issues i.e. where a carer refuses access or if a care provider is unable, unwilling or neglects to meet assessed needs. If the circumstances mean that the care and support needs adult is at risk of significant harm, then Safeguarding Adults procedures should be invoked.

Possible Indicators of neglect:

- Poor condition of accommodation
- Inadequate heating and/or lighting
- Physical condition of person poor, e.g. ulcers, pressure sores etc.
- Person's clothing in poor condition, e.g. unclean, wet, etc.
- Malnutrition
- Failure to give prescribed medication or appropriate medical care
- Failure to ensure appropriate privacy and dignity

- Inconsistent or reluctant contact with health and social agencies
- Refusal of access to callers/visitors

This is not an exhaustive list, nor do these examples prove that there is actual abuse occurring. However, they do indicate that a closer look and possible investigation may be needed.

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

If anyone has concerns that a DWP appointee is acting incorrectly they should contact the DWP immediately. In addition to a name and address the DWP can get things done more quickly if it also has a National Insurance number. The important thing is to alert DWP to their concerns. If DWP know that the person is also known to the local authority then they should also inform them.

A person with capacity may choose to self-neglect, and whilst it may be a symptom of a form of abuse it is not abuse in itself within the definition of these procedures.

In situations of perceived self-neglect involving adults only, the mental capacity of the individual(s) concerned should be assessed. Where there are continued risks steps should be taken to address risks through casework practice and reference to the adults risk management policy.

Self-Neglect

This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

6.7 Discriminatory Abuse

This is abuse targeted at a perceived vulnerability or on the basis of prejudice including racism or sexism, or based on a person's disability. It can take any of the other forms of abuse, harassment, slurs or similar treatment. Discriminatory abuse may be used to describe serious, repeated or pervasive discrimination, which leads to significant harm or exclusion from mainstream opportunities, provision of poor standards of health care, and/or which represents a failure to protect or provide redress through the criminal or civil justice system.

Possible Indicators of discriminatory abuse:

- Hate mail
- Verbal or physical abuse in public places or residential settings
- Criminal damage to property
- Target of distraction burglary, bogus officials or unrequested building/household services

6.8 Institutional (Organisational) Abuse

Institutional abuse happens when the rituals and routines in use force residents or service users to sacrifice their own needs, wishes or preferred lifestyle to the needs of the institution or service provider.

Abuse may be a source of risk from an individual or by a group of staff embroiled in the accepted custom, subculture and practice of the institution or service.

Possible indicators of institutional abuse:

- Institutions may include residential and nursing homes, hospitals, day centres, sheltered housing schemes, group or supported housing projects. It should be noted that all organisations and services, whatever their setting, can have institutional practices which can cause harm to care and support needs adults.
- It may be reflected in an enforced schedule of activities, the limiting of personal freedom, the control of personal finances, a lack of adequate clothing, poor personal hygiene, a lack of stimulating activities or a low quality diet – in fact, anything which treats the person concerned as not being entitled to a 'normal' life.

The distinction between abuse in institutions and poor care standards is not easily made and judgements about whether an event or situation is abusive should be made with advice from appropriate professionals and regulatory bodies.

6.9 Domestic Violence

The Government definition of domestic violence and abuse is:

'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family member regardless of gender or sexuality'.

This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

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

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.' (Home Office 2013)

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 from the source of risk within a context of power and control.

Agencies that are concerned that an adult is subject to domestic abuse should undertake a DASH risk assessment. If they have been trained and where an individual is considered at high risk, a referral to a MARAC should be made. The contact point is Kristy Burns on 01724 244657

Action should always be taken to pass on referrals for all incidents of domestic violence relating to adults, to the Adult Protection Team.

Where a child/young person is suffering domestic abuse or is suffering significant harm as a result of witnessing domestic abuse the LSCB procedures should be followed.

Where there are concerns that a child is involved in or at risk of significant harm as a result of domestic abuse the Single Access Point on 01724 296500/ 01724 296555 (out of office hours) should be contacted.

High risk domestic abuse issues should be referred to a multi-agency risk assessment conference (MARAC) co-ordinated by the North Lincolnshire Domestic Abuse Team. A MARAC is a meeting where information is shared on a multi-agency basis, options are discussed for increasing the safety of the alleged victim and a co-ordinated action plan is produced. The alleged victim does not attend the meeting but is represented by an advocate (Independent Domestic Violence Advocate). The MARAC risk assessment tool and documentation should be used to help identify if the case should be referred to MARAC.

Further information about the MARAC Policy and Procedure can be found
http://www.northlincs.gov.uk/community-advice-and-support/crime-community-safety/multi-agency-risk-assessment-conference-marac/

Honour Based Violence is a crime or incident which has or may have been committed to protect or defend the honour of the family or community. It is a collection of coercive practice which is used to control behaviour within families or other social groups, to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when the source of risk that a relative has shamed the family and/or community by breaking their honour code.

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.

Women are predominately but not exclusively the victims of so called honour based violence which is used to assert male power in order to control female autonomy and sexuality. Honour based violence can be disguised from other forms of violence as it is often committed with some degree of approval and/or collusion from family and/or community members.

Such crimes cut across all cultures, nationalities, faith groups and communities and should be referred on within existing adult protection procedures.

Where children are identified as being involved in, or witness to, honour based violence contact should be made with the Children's Services Single Access Point on 01724 296500/ 2965555

6.10 Modern Slavery

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

Human trafficking

(1) A person commits an offence if the person arranges or facilitates the travel of another person ("V") with a view to V being exploited.

(2) It is irrelevant whether V consents to the travel (whether V is an adult or a child).

(3) A person may in particular arrange or facilitate V's travel by recruiting V, transporting or transferring V, harbouring or receiving V, or transferring or exchanging control over V.

(4) A person arranges or facilitates V's travel with a view to V being exploited only if—

- The person intends to exploit V (in any part of the world) during or after the travel, or
- The person knows or ought to know that another person is likely to exploit V (in any part of the world) during or after the travel.

(5) "Travel" means—

- Arriving in, or entering, any country,
- Departing from any country,
- Travelling within any country.

(6) A person who is a UK national commits an offence under this section regardless of—

- Where the arranging or facilitating takes place, or
- Where the travel takes place.

(7) A person who is not a UK national commits an offence under this section if—

- Any part of the arranging or facilitating takes place in the United Kingdom, or
- The travel consists of arrival in or entry into, departure from, or travel within, the United Kingdom.

6.11 Crime and Anti-Social Behaviour

Antisocial behaviour is any aggressive, intimidating or destructive activity that damages or destroys another person's quality of life; defined by the Crime and Disorder Act 1998 as

‘acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as the defendant’.

7 Who can be the source of risk (source of risk)?

7.1 Care and support needs adults may be abused by anyone, including relatives, carers, professional staff, care staff, volunteers, and other users of services, neighbours, friends or organisations, which allow a culture of poor practice to develop. Professional status or title does not guarantee safety. There are many recent examples of professionals being responsible for abuse.

7.2 More than one person may abuse a care and support needs adult and some sources of risk will abuse more than one alleged victim.

7.3 Abuse does not always just involve the actions of one person towards another. Institutions and services can be guilty of abuse if they persistently fail to take account of the needs of the people using that service or provide inadequate staffing or equipment to enable people’s needs to be met adequately and safely.

8 Predisposing Factors

8.1 Abuse can happen in a range of settings, in a variety of relationships and can take a number of forms. There are a number of indicators, which could, in some circumstances, in combination with other possibly unknown factors, suggest the possibility of abuse. Abuse may be more likely to happen in the following situations:

- Environmental Problems
  - Overcrowding/poor housing conditions/lack of facilities.
- Financial Problems
  - Low income and a dependent care and support needs adult may add to financial difficulties,
  - Inability to work due to caring role,
  - Debt arrears,
  - Full benefits not claimed
- Psychological and Emotional Problems
  - Family relationships over the years have been poor and
  - There is a history of abuse in the family or
  - Where family violence is the norm
- Communication Problems
  - The adult with care and support needs or their carer has difficulty communicating due to sensory impairments, loss or difficulty with speech and understanding,
  - Poor memory or other conditions resulting in diminished mental capacity;
  - This also includes people for whom English is a second language
- Dependency Problems
  - Increased dependency of the person,
  - Major changes in personality and behaviour,
  - Carers are not receiving practical and/or emotional support

- Organisational culture
  - Services which are inward looking,
  - Where there is little staff training/knowledge of best practice
  - Where contact with external professionals is resisted,
  - High staff turnover or shortages may also increase the risk of abuse.

8.2 Patterns of abuse

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

- Serial abuse in which the source of risk seeks out and 'grooms' adult with care and support needs. Sexual abuse may fall into this pattern, as do some forms of financial abuse.
- Long term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations.
- Opportunist abuse such as theft happening because money has been left around.
- Situational abuse which arises because pressures have built up and/or because of difficult or challenging behaviour.
- Neglect of a person's needs because those around him or her are not able to be responsible for their care, for example if the carer has difficulties attributable to such issues as debt, alcohol or mental health problems.
- Stranger Abuse where adult with care and support needs can be targeted by strangers; this may be an individual, a gang, or people offering services (e.g. the conman who tells the older person he will repair their roof, taking a large amount of money but actually does nothing). Different forms of abuse can be inflicted in these situations e.g. financial, physical, and emotional. 'No Secrets' states that:

> 'Stranger abuse will warrant a different kind of response from that appropriate to abuse in an on-going relationship or in a care location. Nevertheless, in some instances it may be appropriate to use the locally agreed inter-agency adult protection procedures to ensure that the care and support needs person receives the services and support that they need. Such procedures may also be used when there is the potential for harm to other care and support needs people.'

8.3 In what circumstances may abuse occur?

Abuse can occur in any setting and may involve any source of risk, not just "hands on" care staff. Vigilance should be exercised with all who have reason to have contact with care and support needs adults, including for example, domestic/ancillary staff, drivers, escorts, contractors and people from voluntary or grant-funded organisations.

Abuse may not be apparent to the person being abused if, for example, they lack capacity and are not aware of the value of money or property. Similarly a person may not know that they have been sexually abused if they do not understand what constitutes appropriate

sexual behaviour. Where a person's capacity to understand that they have been or are being abused is impaired particular vigilance is required if they are to be protected.

8.4 Significantly high levels of risk

High levels of risk may be present even when there are no particular vulnerabilities from abuse. The risk may be classed as significant if an individual, whether a potential victim of abuse or not, presents a level of risk to themselves which could threaten the life of themselves or others.

Examples of significantly high levels of risk would include vulnerability from fire or an exposure to a potentially dangerous situation (road risk, train lines, water risk). These scenarios can, under the appropriate circumstances referred to the Safeguarding Adults Board Risk Panel.

9 Carers and safeguarding

Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include:

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

If a carer speaks up about abuse or neglect, it is essential that they are listened to and that where appropriate a safeguarding enquiry is undertaken and other agencies are involved as appropriate.

If a carer experiences intentional or unintentional harm from the adult they are supporting, or if a carer unintentionally or intentionally harms or neglects the adult they support, consideration should be given to:

- Whether, as part of the assessment and support planning process for the carer and, or, the adult they care for, support can be provided that removes or mitigates the risk of abuse. For example, the provision of training or information or other support that minimises the stress experienced by the carer. In some circumstances the carer may need to have independent representation or advocacy; in others, a carer ay benefit from having such support if they are under great stress or similar; and
- Whether other agencies should be involved; in some circumstances where a criminal offence is suspected this will include alerting the police, or in others the primary healthcare services may need to be involved in monitoring.

Other key considerations in relation to carers should include:

- Involving carers in safeguarding enquiries relating to the adult they care for, as appropriate;
- Whether or not joint assessment is appropriate in each individual circumstance;

- The risk factors that my increase the likelihood of abuse or neglect occurring; and
- Whether a change in circumstance changes the risk of abuse or neglect occurring. A change in circumstance should also trigger the review of the care and support plan and, or, support plan.

Chapter 2

Roles and Responsibilities

10 Statutory Partners & Responsibilities

The lead duty for the coordination of procedures to protect care and support needs adults lies with the three lead agencies identified under the Care Act. These are the North Lincolnshire Council People Directorate, North Lincolnshire Clinical Commissioning Group and Humberside Police.

They have the lead role in coordinating the multi-agency approach to safeguard adults at risk. This includes the coordination of the application of this policy and procedures, coordination of activity between organisations, review of practice, facilitation of joint training, dissemination of information and monitoring and review of progress within the local authority area.

The Governance for safeguarding duties are discharged through the North Lincolnshire Safeguarding Adults Board which consists of representatives from the local statutory groups named above that have responsibilities under the Care Act and non-statutory organisations that are also involved in providing support to adults who have care and support needs. These organisations include Humberside Fire Rescue Service, North Lincolnshire Homes, The National Probation Service, Voluntary Sector organisation, Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH), North Lincolnshire and Goole NHS Foundation Trust (NLaG) and Independent Sector Providers.

The three lead agencies should:

- Ensure that any Safeguarding Adults concern is acted on in line with this policy and procedures
- Coordinate the actions that relevant organisations take in accordance with their own duties and responsibilities. This does not mean that the local authorities undertake all activities under Safeguarding Adults – relevant organisations have their own roles and responsibilities
- Ensure a continued focus on the adult at risk and due consideration to other adults or children
- Ensure that key decisions are made to an agreed timescale
- Ensure that an interim and a final protection plan are put in place with adequate arrangements for review and monitoring
- Ensure that actions leading from investigation are proportionate to the level of risk and enable the adult at risk to be in control, unless there are clear recorded reasons why this should not be the case
- Ensure independent scrutiny of circumstances leading to the concern and to
- Facilitate learning the lessons from practice and communicate these to the Safeguarding Adults Board.

10.1 Adult Protection Team

The lead role for the coordination of safeguarding adults alerts and any subsequent Section 42 enquiries investigation is the responsibility of North Lincolnshire Council Adult Services. This is managed through Adult Protection Team.

Adult Protection Team
Adult Services
North Lincolnshire Council
Church Square House
PO Box 42
Scunthorpe
North Lincolnshire
DN15 6XQ

Telephone: 01724 297979
Fax: 01724 298194
Email: adultprotectionteam@northlincs.gov.uk

Chapter 3

Obligations and Duties

Roles and responsibilities of organisations

This multi-agency procedure sets out what is expected of staff working within any organisations that have contact with care and support needs adults. All staff must work within the framework of best practice and know what their responsibilities are under the procedure and to whom they should report. Organisations should have internal guidance for their own staff that complements this multi-agency procedure.

11 Information Sharing Guidance

'The Care Act' says that the government expects organisations to be sharing information about individuals who may be at risk from abuse. It is important to identify an abusive situation as early as possible so that the individual can be protected. Withholding information may lead to abuse not being dealt with early enough. Confidentiality must never be confused with secrecy with the needs of the individual the primary concern- see "Care and Support Statutory Guidance" which replaces 'No Secrets guidance'.

> 'If someone knows that abuse or neglect is happening they must act upon that knowledge, not wait to be asked for that information'

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

11.1 Record Keeping

Good record keeping is vital. All agencies need to keep clear and accurate records.

Staff should be given clear direction about what should be recorded and in what format using the following as a guide:

- What information do staff need to know in order to provide a high quality response to the adult concerned
- What information do staff need to know in order to keep adults safe under the service's duty to protect people from harm
- What information is not necessary
- What is the basis for any decision to share (or not) information with a third party

Agencies need to identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those adults affected by,

and subject to, any enquiry If an alleged source of risk is also a recipient of care or support then information about their involvement in a safeguarding enquiry should be included in their case record.

11.2 Purpose Of Information Sharing

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

- A criminal offence has taken place
- It may prevent crime
- The alleged victim is at risk of harm
- Staff, other service users, or the general public may be at risk of harm
- For early intervention and identification of abuse
- For investigations under Safeguarding Adults procedures and to understand what went wrong

If other reasons for sharing information are subsequently identified, these will be considered and amendments approved by the appropriate Caldicott Guardians of the partner organisations.

Where personal information is shared it will be maintained securely and in accordance with the Data Protection Act. Each employing agency will take steps to ensure that any disclosure to other agencies of personal information is on a strict 'need to know' basis, according to their own internal procedures and agreed protocols. Any action taken as a consequence of this information is entirely the responsibility of the employing agency. (link to safer recruitment)

11.3 Information sharing when the care and support needs adult has given consent

There are situations where information can be shared legally without obtaining the consent from an individual. An element of information sharing will need to happen as part of the Strategy Meeting/discussion where initial assessments of the risk factors affecting a potentially care and support needs adult are made.

In this situation information can be shared without consent, relying upon statutory powers and duties. As part of the Strategy meeting the following decisions will be made:

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

Even if there is no legal requirement to obtain consent before sharing information, it is often good practice to do so. The emphasis throughout this protocol is a presumption of person led decisions and on obtaining the informed consent of the alleged victim to share information at the first point of contact.

Informed consent is a freely-given specific and informed indication of a person's agreement to a course of action where information is given to that person about the proposed course of

action. It may be expressed verbally or in writing (except where an individual cannot write or speak when other forms of communication may be sufficient). Consent may be given in the form of an advanced statement.

Where a person struggles to understand local authority safeguarding processes they must be informed of their right to an independent advocate.

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

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

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

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

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

11.4 Information sharing when an adult with care and support needs does not have the capacity to consent to information sharing

If an adult is not competent to make their own decisions, professionals should share information that is in their 'best interests'. The capacity to be able to give consent can be assessed by considering:

- Has the person got the ability or power to make a particular decision
- Have they got the ability to understand and retain the information relevant to the decision

- Will they be able to understand the reasonably foreseeable consequences of deciding one way or the other
- Will they have the ability to communicate the decision they have come to

The adult must be informed of their right to an independent advocate.

Where a person is not the legal representative but acts as 'carer' to a person not capable of giving consent, we have to consider whether they are acting on their behalf and in the individual's best interests. As long as the individual's rights are not adversely affected and we act in the best interests of that individual, we have to get the best form of consent we can at the time a decision has to be made.

11.5 Best Interest

The Mental Capacity Act 2005 (section 4) and The Code of Practice set out the best interest's checklist to which professionals must have regard when determining what is in the best interests of an individual.

Where an adult with is judged to lack capacity in relation to a specific decision, this decision should be made in their 'best interests'.

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

- Ascertainable past and present wishes and feelings of the person concerned and the factors the person would consider if able to do so.
- The need to encourage the person to participate as fully as possible in decisions.
- The views of other people whom it is appropriate and practical to consult about the person's wishes and feelings and what would be in their best interests.
- Any person named by the service user as someone to be consulted on those matters.
- Anyone (whether a spouse, relative, friend or other person) engaged in caring for the service user or interested in the service user's welfare.
- The holder of any continuing power of attorney.
- Any manager appointed for him by the court.
- Achieving the purpose of an action or decision by means which least restrict the freedom of action of the person.
- If someone is unable to give consent and there is no-one to represent them, we should record that they cannot give consent and only share information where necessary in their best interests or where we have a statutory duty to provide care.
- If an adult is unable to give informed consent, then decisions to disclose information will generally be taken by the professional concerned. Any decision should take into account the person's best interests and as necessary the views of relatives and carers. An earlier refusal to particular information being passed on, given while the person had capacity to decide, should normally be regarded as decisive.

- Where a service user's capacity may change from day to day (for example as a consequence of fluctuating mental health), a decision on consent should be deferred wherever possible, until such a time as they are able to be involved in the decision making process, as long as this does not adversely impact on the vulnerability of the adult.
- Where it is considered that a service user does not have the capacity, a record should be made of this decision and the steps taken by the professional to reach a decision about whether information should be shared.

11.6 Information sharing when the adult withholds consent to share information

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

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

The worker must explain to the person why the disclosure needs to take place and to whom the information will be passed. This should generally be done unless it would increase the risks of harm. Workers must consider whether there is an overriding public interest that would justify information sharing (e.g. because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldicott Guardian should be involved*.

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

Decisions to share without consent must make sure that it does not interfere with that person's human rights.

The Care Act states that it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse particularly in those situations when other adults may be at risk.

11.7 Sharing information with carers, parents, family, partners etc

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

When the adult does not have the capacity, consideration should be given to when to share information with carers/parents of the adult. In addition, consideration must be given to the relationship between the carers/parents and the alleged source of risk. Clear decisions

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

11.8 Sharing Information with third parties about the (alleged) source of risk

Information in a range of media should be produced in different, user-friendly formats for people with care and support needs and their carers. These should explain clearly what abuse is and also how to express concern and make a complaint. Adults with care and support needs and carers should be informed that their concern or complaint will be taken seriously, be dealt with independently and that they will be kept involved in the process to the degree that they wish to be. They should be reassured that they will receive help and support in taking action on their own behalf. They should also be advised that they can nominate an advocate or representative to speak and act on their behalf if they wish.

Organisations and workers must 'honestly and reasonably believe' that the sharing of information is necessary to protect adults with care and support needs or the wider public and must use the test of 'pressing social need'. To pass this test the relevant organisation must consider the following issues:

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

Decisions about who needs to know and what needs to be known should be taken on a case by case basis. It is vital there is a balancing exercise undertaken weighing the serious consequences of disclosure against risks to adults with care and support needs. Clearly the issue of proportionality will be vital.
This decision will be made at the strategy discussion stage, where it will be determined who within the investigation team will contact and speak to the alleged source of harm and how this will be managed.

11.9 Disclosures to other organisations outside of the Safeguarding Case Conference

There may, exceptionally, be some cases where the risk posed by an individual in the community cannot be managed without the disclosure of some information to a third party outside statutory organisations. Such an example would be where an employer, voluntary group organiser or church leader has a position of responsibility/control over the individual and other persons who may be at serious risk. Caution should be exercised before making any such disclosure: it should be seen as an exceptional measure. The following check list may be of assistance:

- The individual presents a risk of serious harm to the adult with care and support needs, or to those for whom the recipient of the information has responsibility. The right person will be the person who needs to know in order to avoid or prevent the risks.
- There is no other practical, less intrusive means of protecting the care and support needs adult, and failure to disclose would put them in danger. Also, only that information which is necessary to prevent harm should be disclosed, which will rarely be all the information available.
- The risk to the individual should be considered although it should not outweigh the potential risk to others were disclosure not to be made. The individual retains their rights (most importantly their Article 2 right to life) and consideration must be given to whether those rights are endangered as a consequence of the disclosure.
- The disclosure is to the right person and that they understand the confidential and sensitive nature of the information they have received. The information will not be disclosed by the recipient third party without the express permission of the original disclosing organisation. Consider consulting the individual about the proposed disclosure. This should be done in all cases, unless to do so would not be safe or appropriate. If it is possible and appropriate to obtain the individual's consent, then a number of potential objections to the disclosure are overcome. Equally, the individual may wish to leave the placement rather than have any disclosure made. If appropriate, this would also avoid the need for disclosure.
- Ensure that whoever has been given the information knows what to do with it. Again, where this is a specific person, this may be less problematic but in the case of an employer, for example, advice and support may need to be given.

12 Capacity, Consent and Decision Making

12.1 The consideration of capacity is crucial at all stages of Safeguarding Adults procedures. For example determining the ability of an adult to make lifestyle choices, such as choosing to remain in a situation where they risk abuse; determining whether a particular act or transaction is abusive or consensual; or determining how adult with care and support needs can be involved in making decisions in a given situation.

12.2 The key development affecting this area of work is the implementation of the Mental Capacity Act 2005, which provides a statutory framework to empower and protect adults who may not be able to make their own decisions. It makes it clear who can take decisions in which situations and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. It applies to anyone aged 16 years and over therefore appropriate liaison needs to occur for young people aged 16 to 18 years with Children's Services.

12.3 The whole Act is underpinned by a set of five key principles:

- A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;

- The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
- That individuals must retain the right to make what might be seen as eccentric or unwise decisions;
- Best interests - anything done for or on behalf of people without capacity must be in their best interests; and
- Least restrictive intervention - anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

Mental Capacity Act 2005 sections 2 (1), Code of Practice 4.11 – 4.13
Section 2 states that a person lacks capacity in relation to a matter if at the material time s/he is unable to make a decision for himself or herself in relation to the matter because of an impairment of, or a disturbance, in the functioning of the mind or brain.

Mental Capacity Act 2005 section 3, Code of Practice 4.49 – 4.54

Section 3 states that a person is unable to make a decision if s/he is unable:

- To understand the information relevant to the decision
- To retain the information
- To use or weigh that information as part of the process of making the decision
- To communicate his decision by any means.

Every assessment of capacity must be undertaken in accordance with the Act and provisions of the Code of Practice. Where there is a reasonable belief that a person lacks capacity, there is a statutory best interest checklist for people acting on behalf of others. The decision maker must work through the factors when deciding what is in the best interests of the individual.

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

- Lasting powers of attorney (LPAs) - The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This allows people to let an attorney make health and welfare and / or financial decisions. The latter is similar to previously available Enduring Power of Attorney (EPA).
- Court appointed deputies - The Act provides for a system of court appointed deputies to replace the current system of receivership in the Court of Protection. Deputies will be able to take decisions on welfare, healthcare and financial matters as authorised by the Court but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues.

12.5 The Act created two public bodies to support the statutory framework, both of which are designed around the needs of those who lack capacity:

- A Court of Protection - The Court has jurisdiction relating to the whole Act and will be the final arbiter for capacity matters. It has its own procedures and nominated judges.
- A Public Guardian - The Public Guardian and his/her staff are the registering authority for Lasting Power of Attorney (LPAs) and deputies. They supervise deputies appointed by the Court and provide information to help the Court make decisions. They also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board scrutinises and reviews the way in which the Public Guardian discharges his/her functions. The Public Guardian is required to produce an Annual Report about the discharge of his/her functions.

12.6 The Act also includes further key provisions to protect people with care and support needs:

- **Advance decisions to refuse treatment**
  Statutory rules with clear safeguards confirm that people may make a decision in advance to refuse treatment if they should lose capacity in the future. It is made clear in the Act that an advance decision will have no application to any treatment, which a doctor considers necessary to sustain life, unless strict formalities have been complied with. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands 'even if life is at risk'.

- **A criminal offence**
  The Act introduces two new criminal offences of 'ill treatment' or 'wilful neglect' of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

- **Independent Mental Capacity Advocate (IMCA)**
  The purpose of the Independent Mental Capacity Advocacy Service is to help particularly people with care and support needs who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

The Department of Health has extended the Act through Regulations to cover circumstances where a Safeguarding Adults allegation has been made. The Regulations specify that Local Authorities and the NHS have powers to instruct an IMCA if the following requirements are met:

- Where safeguarding measures are being put in place in relation to the protection of care and support needs adults from abuse; and
- Where the person lacks capacity.

In these circumstances the Local Authority or NHS body may instruct an IMCA to represent the person concerned, if it is satisfied that it would be of benefit for the person to do so. Safeguarding Adults cases access to IMCAs is not restricted to people who have no one else to support or represent them. People who lack capacity who have family and friends can still have an IMCA to support them through the safeguarding process.

The regulations equally apply to a person who may have been abused or neglected and a person who is alleged to be the source of risk.

Where the qualifying criteria are met, it would be unlawful for the Local Authority or the NHS not to consider the exercise of their power to instruct an IMCA for Safeguarding Adults cases.

- **Restraint**
  Section 5 permits the use of restraint if the person using it reasonably believes that it is necessary to prevent harm to the person who lacks capacity and if the restraint is proportionate to the likelihood and seriousness of harm. However, where the restriction or restraint is frequent, cumulative and ongoing then consideration should to be given to whether this amounts to deprivation of liberty. In April 2009 the Mental Capacity Act was amended to include provision for the deprivation of liberty for those who need to be accommodated under circumstances that deprives them of their liberty. Refer to Mental Capacity Act 2005, Deprivation of Liberty Safeguards Code of Practice.

13 Risk Management

13.1 Risk assessment and risk management are essential aspects of adult protection; they must be included in the measures taken to prevent abuse or mitigate risk as well as being an integral part of the protection plan in response to actual allegations or suspicion of abuse.

13.2 Risk assessments are undertaken by a variety of professionals; they may encompass different assessment tools and be recorded in a variety of formats. Workers should follow organisational policies and share the results in accordance with the Safeguarding Adults Information Sharing Protocol.

13.3 In assessing the seriousness of the risk the following should be considered:

- The vulnerability of the individual
  - The extent of any cognitive impairment
  - Their level of physical dependency
  - Their level of emotional dependency
  - Their level of financial dependency
  - Their ability to communicate
  - Their social and cultural isolation
- The nature and extent of the abuse/risk
- The length of time over which the abuse has been happening
- The impact on the individual

- The impact on others
- Whether the situation can be monitored

13.4 In assessing the likelihood of an abusive situation reoccurring, the following should be considered:

- Whether there is a history of domestic violence or abuse
- The intent of the alleged source of risk – was it a deliberate act or a lack of awareness
- The existence of known predisposing factors or triggers
- The supportive measures that can be put in place
- Whether the situation can be monitored

13.5 The risk should be considered high if:

- There is reason to believe someone's life may be in danger
- There is reason to believe that major injury or serious physical or mental ill health could result
- The incidents are increasing in frequency
- The incidents are increasing in severity
- The behaviour is persistent and/or deliberate.

13.6 North Lincolnshire Safeguarding Adults Board has a Positive Risk Policy which provides more comprehensive information to support professionals

14 Safeguarding Adult Review (SAR)

14.1 The North Lincolnshire Safeguarding Adults Board must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. It is the responsibility of the three lead agencies for safeguarding to ask the SAR Group to consider whether a referral meets the criteria for a full safeguarding adults review. This recommendation must be taken back to the Safeguarding Adult Board chair for their final decision.

14.2 The SAB must also arrange a SAR if an adult in its area has not died, but the SAB knows of, 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 as a result of abuse or neglect. SAB's are free to arrange for a SAR in any other situations involving an adult in its area with care and support needs.

14.3 SARs can also be arranged to explore examples of good practice where this is likely to identify lessons that can be applied in future.

14.4 The SAB should determine what type of review will promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

14.5 Discussions will need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is subject to a SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.

14.6 SAR's should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This 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. Other processes exist for that, including criminal proceedings, disciplinary procedures, and employment law.

14.7 It is vital if individuals and organisations are to be able to learn lessons from the past that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them, If individuals and organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

14.8 The process for undertaking SARs is determined locally according to the specific circumstances of individual cases. No one model is applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and often answers for families and friends of adults who have died or been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the SAB.

14.9 The procedure for undertaking Safeguarding Adult Reviews is in the learning and development framework see Appendix 1.

15 North Lincolnshire Safeguarding Adults Board

Under the Care Act 2014, each local authority must set up a Safeguarding Adults Board (SAB).

The SAB has a strategic role in relation to safeguarding adults. It oversees and leads adult safeguarding across North Lincolnshire and has responsibility for the prevention of abuse and neglect. These include the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services. It is important that SAB partners feel able to challenge each other and organisations where it believes that their actions or inactions are increasing the risk of abuse or neglect. This will include commissioners as well as providers of services.

The main objective of a SAB is to assure itself that local safeguarding arrangements and partners help and protect adults in its area who meet the criteria as in 14.2 of the Act.

The Safeguarding Adults Board promotes proactive collaboration between partners in order to create a framework of inter-agency arrangements. The Care Act states that local authorities and their relevant partners must collaborate and work together as set out in the co-operation duties in the Care Act.

The lead agency with responsibility for coordinating adult safeguarding arrangements is the local authority, however, all members of the SAB should designate a lead officer. Other agencies should also consider the benefits of having a lead for adult safeguarding.

Members of the SAB are expected to consider what assistance they can provide in supporting the Board in its work. This may be through a variety of means including meeting attendance, discussions contribution and payment as a joint contribution: all partners have to ensure that the SAB is adequately resourced to carry out its functions.

The SAB has three core duties:

- It must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation in preparing the plan. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.

- It must publish an annual report detailing what both the SAB and its members have done, to carry out and deliver the contents of the strategic plan. The report must provide information about any safeguarding adult reviews that the SAB arranged which are ongoing or have been reported in that year. The report should also set out how the SAB is monitoring progress against its policies. The SAB should publish the report on its website. The SAB should send a copy of the report to:

    - The Chief Executive of the local authority
    - The Police and Crime Commissioner and Chief Constable
    - Local Health watch
    - The Chair of the Health and Wellbeing Board.

- It must conduct any Safeguarding Adults Reviews in accordance with Section 44 of the Act.

In addition each SAB should:

- Identify the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults;
- Establish ways of analysing and interrogating data on safeguarding notifications that increase the SAB's understanding of prevalence of abuse and neglect locally that builds up a picture over time;
- Establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements;
- Determine its arrangements for peer review and self-audit;

- Establish mechanisms for developing policies and strategies for protecting adults which should be formulated, to also take account of the views of adults who have needs for care and support, their families, advocates and carer representatives;
- Develop preventative strategies that aim to reduce instances of abuse and neglect in its area
- Identify types of circumstances giving grounds for concern and when they should be considered as a referral to the local authority as an enquiry;
- Develop strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect;
- Balance the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a 'need-to-know basis';
- Identify mechanisms for monitoring and reviewing the implementation and impact of policy and training;
- Evidence how SAB members have challenged one another and held other boards to account; and,
- Promote multi-agency training and consider any specialist training that may be required.

15.1 Board Membership

The following organisations must be represented on the Board:

- The Local Authority
- The NHS Clinical Commissioning Group
- The Chief Officer of Humberside Police
- The Board may also include other organisations and individuals as it considers appropriate having consulted its key SAB partners as detailed above

Other organisations represented on North Lincolnshire's SAB are:

- The ambulance service
- The fire service
- Independent Providers
- Housing Services
- Probation Service
- Healthwatch
- Representative of the LSCB
- NHS England
- National Offender Management Service - Prison Service
- Rotherham, Doncaster and South Humber Mental Health Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- General Practitioners
- Representatives of user advocacy and carers groups
- Care Quality Commission

The board will invite advisors as required to contribute to the board and its Action Group meetings.

The Board also ensures proactive links with:

- The Community Safety Partnership
- The Local Safeguarding Children's Board
- The Health and Wellbeing Board

15.2 Roles and responsibilities of the of the Safeguarding Adult Board Chair

The Board is chaired by someone who is not an employee or member of any agency that is a member of the SAB. The Chair is independent of all agencies. The Chair's role is to lead collaboratively, give advice, support and encouragement but to also offer constructive challenge and hold main partners to account. The Chair is accountable to the Chief Executive of the local authority.

For further information on the purpose and function of the North Lincolnshire Safeguarding Adults Board, please see the Memorandum of Understanding.

Cross border agreement

The increased risk to adults whose care arrangements are complicated by cross boundary considerations must be recognised. The authority where the abuse happened (host authority) should always take the initial lead on responding to the referral.

Section B

North Lincolnshire Procedures

Chapter 4

Stages of the Safeguarding Adults Process

16 Reporting and responding to abuse and neglect

In order to respond appropriately where abuse or neglect may be taking place, anyone in contact with the adult, whether in a volunteer or paid role, must understand their role and responsibility and have access to practical and legal guidance, advice and support. This will include understanding this multi-agency procedure.

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

The circumstances surrounding any actual or suspected case of abuse or neglect will inform the response from the Adult Protection Team. Where the safeguarding concerns arise from abuse or neglect deliberately intended to cause harm, then it would not only be necessary to immediately consider what steps are needed to protect the adult but also whether to refer the matter to the police to consider whether a criminal investigation would be required or appropriate.

The decision to report a safeguarding concern to the Adult Protection Team can be done after consideration and measurement against the safeguarding threshold document. This document has been in place in North Lincolnshire for a significant period of time and has been updated to reflect the changes within the Care Act 2014.

Threshold Document

Type of Abuse	**Lower Level Harm** Could be addressed via agency internal process/procedures e.g. disciplinary, care management or consider referral to safeguarding to be made. It is not a 'given' that any concerns falling into this section would be dealt with internally.		**Significant/ Very Significant Harm** Addressed under Safeguarding Procedures – referral to safeguarding to be made.		**Critical** Addressed as potential criminal matter – contact Police/ Emergency Services – could be addressed as MAPPA, MARAC, Hate crime.
Physical **A**	Staff error causing no / little harm, e.g. skin friction mark due to ill-fitting hoist sling Minor events that still meet criteria for 'incident reporting'	Isolated incident involving service user on service user Inexplicable very light marking found on one occasion	Inexplicable marking or lesions, cuts or grip marks on a number of occasions	Inappropriate restraint Withholding of food, drinks or aids to independence Inexplicable fractures/ injuries Assault	Grievous bodily harm/ assault with weapon leading to irreversible damage or death
Sexual **B**	Isolated incident of teasing or low-level unwanted sexualised attention (verbal or touching) directed at one adult by another whether or not capacity exists	Verbal sexualised teasing or harassment	Recurring sexualised touch or masturbation without valid consent Being subject to indecent exposure Contact or non-contact sexualised behaviour which causes distress to the person at risk	Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent Being made to look at pornographic material against will/ where valid consent cannot be given	Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user Sex without valid consent (rape) Voyeurism
Psychological	Isolated incident where adult is spoken to in a rude or	Occasional taunts or verbal outbursts	Treatment that undermines dignity	Humiliation	Denial of basic human rights/ civil liberties, over-riding advance

C	inappropriate way – respect is undermined but no or little distress is caused	which cause distress The withholding of information to dis-empower	and damages esteem Denying of failing to recognise an adult's choice or opinion Frequent verbal outbursts	Emotional blackmail e.g. threats of abandonment / harm Frequent and frightening verbal outbursts	directive, forced marriage Prolonged intimidation Vicious / personalised verbal attacks
Financial or Material **D**	Money is not recorded safely or recorded properly	Adult not routinely involved in decisions about how their money is spent or kept safe – capacity in this respect is not properly considered	Adult's monies kept in a joint bank account – unclear arrangements for equitable giving of interest Adult denied access to his/ her own funds or possessions	Misuse/ misappropriation of property, possessions or benefits by a person in a position of trust or control. To include misusing loyalty cards Personal finances removed from adult's control	Fraud/ exploitation relating to benefits, income, property or will Theft
Neglect or acts of omission **E**	Isolated missed home care visit – no harm occurs Adult is not assisted with a meal/drink on one occasion and no harm occurs Adult does not receive prescribed medication (missed/ wrong dose) on one occasion – no harm occurs	In adequacies in care provision leading to discomfort – no significant harm e.g. left occasionally wet No access to aids for independence Recurring missed medication or administration errors that cause no harm	Recurrent missed home care visits where risk of harm escalates, or one miss where harm occurs Hospital discharge, no adequate planning and harm occurs Recurring missed medication or errors that affect one or more than one adult and/ or result in harm	Ongoing lack of care to extent that health and well-being deteriorate significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/ confidence Deliberate maladministration of medications	Failure to arrange access to life saving services or medical care Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death

				Covert administration without proper medical authorisation	
Discriminatory **F**	Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences	Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period Recurring taunts	Inequitable access to service provision as a result of diversity issue Recurring failure to meet specific care/ support needs associated with diversity	Being refused access to essential services Denial of civil liberties e.g. voting, making a complaint Humiliation or threats on a regular basis	Hate crime resulting in injury/ emergency medical treatment/ fear for life Hate crime resulting in serious injury/ attempted murder/ honour-based violence
Organisational **G**	Lack of stimulation/ opportunities to engage in social and leisure activities Service User not enabled to be involved in the running of the service Service design where groups of service users living together are incompatible	Denial of individuality and opportunities to make informed choices and take responsible risk Care-planning documentation not person-centred Poor, ill formed or outmoded care practice no significant harm Denying service user access to professional support and services such as advocacy	Rigid/ Inflexible routines, service users' dignity is undermined e.g. lack of privacy during support with intimate care needs, pooled under-clothing Failure to whistle blow on serious issues when internal procedures to highlight issues are exhausted Failure to refer disclosure of abuse	Bad practice not being reported and going unchecked Unsafe and unhygienic living environments Failure to support care and support needs adult to access health, care, treatments Punitive responses to challenging behaviours	Staff misusing position of power over service users Over-medication and/ or inappropriate restraint managing behaviour Widespread, consistent ill treatment Entering into a sexual relationship with a patient/ client

Self-Neglect **H**	This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding – if the person lacks capacity please refer to the Mental Capacity Act Code of Practice for guidance on undertaking best interest decisions. If the person has capacity contact the Adult Protection Team if further advice or guidance is required.
Domestic Violence **I**	Includes psychological, physical, sexual, financial, emotional abuse, so called 'honour' based violence, female genital mutilation, forced marriage. Please refer to the Care and support needs Adult Decision Maker in the Police Protecting Care and support needs People (PVP) Unit - Can be contacted via the Adult Protection Team
Modern Slavery **J**	Encompasses slavery, human trafficking, forced labour and domestic servitude. Please refer to the Care and support needs Adult Decision Maker in the Police Protecting Care and support needs People (PVP) Unit – Can be contacted via the Adult Protection Team
Sexual Exploitation **K**	Sexual exploitation is a subset of sexual abuse. It involves exploitative situations and relationships where people receive 'something' (eg accommodation, alcohol, affection, money) as a result of them performing, or others performing on them, sexual activities. Please refer to the Care and support needs Adult Decision Maker in the Police Protecting Care and support needs People (PVP) Unit – Can be contacted via the Adult Protection Team

If any doubt remains or advice is needed please contact a member of the Adult Protection Team to discuss the concern.

Adult Protection Team details

Adult Protection Team
Adult Services
North Lincolnshire Council
Church Square House
PO Box 42
Scunthorpe
North Lincolnshire
DN15 6XQ

Telephone: 01724 297979
Fax: 01724 298194
Email: adultprotectionteam@northlincs.gov.uk

The flowcharts below show the pathway for any safeguarding concern. This is a national pathway as laid out in the Care act 2014. See this section for guidance on reporting a safeguarding concern to the Adult Protection Team.

The alert form to use for any concern can be accessed via this link

http://www.northlincs.gov.uk/people-health-and-care/worried-about-someone/worried-about-an-adult/

Early sharing of information is the key to providing an effective response where there are emerging concerns.

No professional should assume that someone else will pass on the information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the Adult Protection Team, and, or the police if they believe or suspect that a crime has been committed.

17 Local Authority's role and multi-agency working

Local Authorities must cooperate with each of their relevant partners, as described in section 6 (&) of the Care Act, and those partners must also cooperate with the local authority, in the exercise of their responsibilities relevant to care and support including those to protect adults.

Relevant partners are Humberside Police and the following agencies or bodies who operate within the Council area including:

- NHS England
- Department for Work and Pensions
- North Lincolnshire Voluntary Action Service
- Her Majesties Probation Services

- Northern Lincolnshire and Goole Hospitals NHS Trust
- Private providers of health and social care
- Humberside Fire and Rescue

18 Safeguarding Enquiries

The Care Act has replaced terminology of alerts and referrals and now talks about concerns and enquiries.

18.1 What is a Safeguarding Concern?

This is the first contact between a person concerned about abuse or neglect and the local authority. This is the same as an alert in the old procedures. In North Lincolnshire Council the local authority role is undertaken by staff in the Adult Protection Team. A care concern is where the alerter raises a concern regarding the health and well-being of a vulnerable adult, or raises concerns regarding services provided by a health or social care provider. A safeguarding concern is an occurrence which meets the ADASS threshold and requires further fact-finding or a formal investigation (Section 42 Enquiry).

18.2 What is a Safeguarding Enquiry?

Any enquiry made or instigated by the Adult Protection Team after receiving a safeguarding concern. Queries raised by the Adult Protection team during the safeguarding concern should not be classed as an enquiry.

An enquiry:

- Should establish whether any action needs to be taken and if so, by whom
- Could range from an informal conversation with the adult at risk to a more formal multi-agency discussion
- Does not have to follow a formal safeguarding process
- Establish on the balance of probabilities, if abuse or neglect has occurred
- If abuse or neglect has occurred, to establish which type of abuse and by whom
- Consideration should then be given to the referring to the Disclosure and Barring Service or other professional bodies so the potential future risk of the perpetrator can be assessed and shared if appropriate
- The responsibility to refer to these organisations rests with the employer

The flowchart on the following page shows the pathway and process that will be undertaken in North Lincolnshire once a concern is raised with the Adult Protection Team.

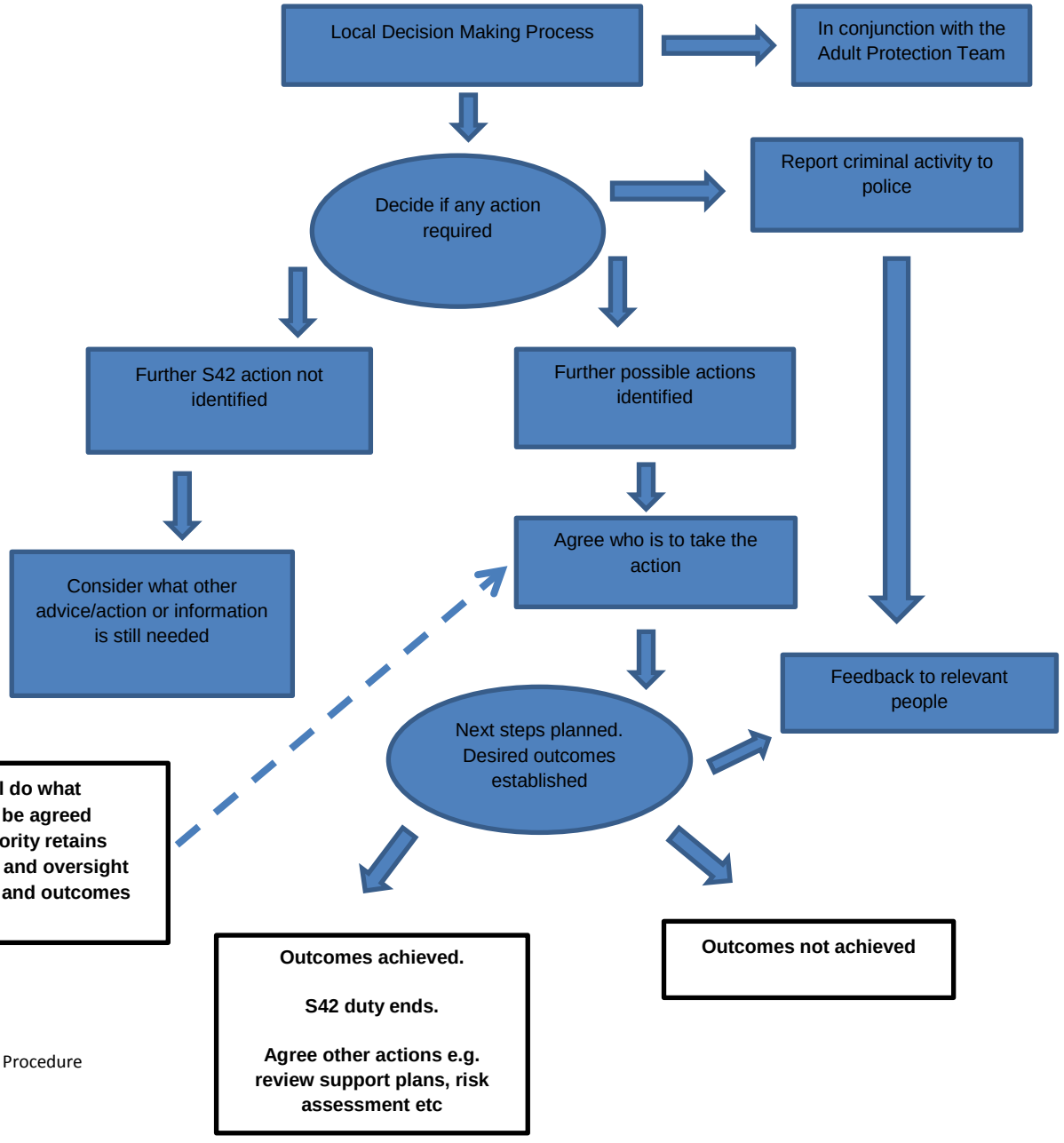
North Lincolnshire Adult Safeguarding in Action

What is a safeguarding concern?

A safeguarding concern is an occurrence which meets the ADASS threshold and requires further fact-finding or a formal investigation (Section 42Enquiry).

What is a safeguarding enquiry?

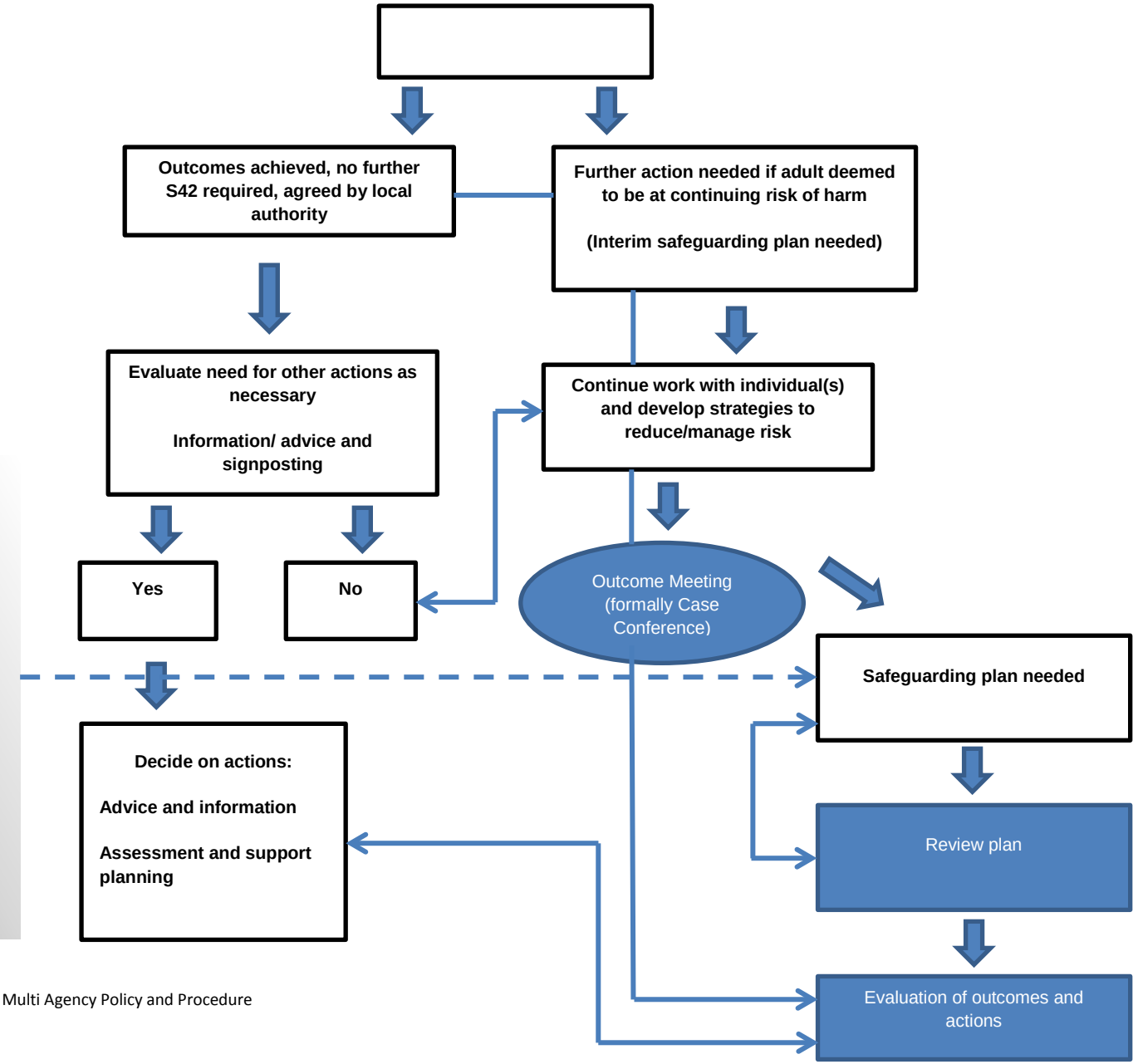
An enquiry is made or instigated by the Adult Protection Team after receiving a safeguarding concern.



Principles

- **Empowerment** presumption of person led decisions and informed consent
- **Prevention** It is better to take action before harm occurs
- **Proportionate** and least intrusive response appropriate to the risk presented
- **Protection** Support and representation for those in greatest need
- **Partnership** Local solutions through services working with their communities
- **Communities** have a part to play in preventing, detecting and reporting neglect and abuse
- **Accountability** and transparency in delivering safeguarding

North Lincolnshire Safeguarding in Action



Safeguarding Plan:

- **Timescales for review and monitoring to be agreed**
- **Agree who will be the lead professional to monitor and review the plan**
- **Ensure all professionals are clear about their roles and actions**

Principles

- **Empowerment** presumption of person led decisions and informed consent
- **Prevention** It is better to take action before harm occurs
- **Proportionate** and least intrusive response appropriate to the risk presented
- **Protection** Support and representation for those in greatest need
- **Partnership** Local solutions through services working with their communities
- **Communities** have a part to play in preventing, detecting and reporting neglect and abuse
- **Accountability** and transparency in delivering safeguarding

Any concern about an adult with care and support needs who is at risk of abuse or neglect should be made as soon as possible to staff at the Adult Protection Team. Staff within the Adult Protection Team work closely with other partner agencies, including the police and health. Their role is to decide if an incident meets the criteria for a safeguarding concern, carry out safeguarding enquiries and quality assure enquiries carried out by other agencies.

The Adult Protection Team will decide if the incident is a safeguarding concern and who is the most appropriate agency to carry out the enquiry.

The best way to contact is by telephone on 01724 297979.

This is described in the flowchart as “local decision making process”

Once a concern is identified the first priority should always be to ensure the safety and well-being of the adult. The adult should experience the safeguarding process as empowering and supportive. Practitioners should wherever practicable seek the consent of the adult before taking action. However, there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interests to undertake an enquiry. Whether or not the adult has the capacity to given consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action because a criminal offense has occurred. It is the responsibility of all staff and members of the public to act on any suspicion of evidence of abuse or neglect and to pass on their concerns to their own agency or the Adult Protection Team.

This extract from the statutory guidance gives more detail to the issue of consent

“…where a competent adult explicitly refuses any supporting intervention, this should normally be respected. Exceptions to be this may be where a criminal offence may have taken place or where there may be significant risk of harm to a third party. If, for example, there may be an abusive adult in a position of authority in relation to other care and support needs adults [sic], it may be appropriate to breach confidentiality and disclose information to an appropriate authority. Where a criminal offence is suspected it may also be necessary to take legal advice. Ongoing support should also be offered. Because an adult initially refuses the offer of assistance he or she should not therefore be lost to or abandoned be relevant services. The situation should be monitored and the individual informed that she or he can take up the offer of assistance at any time.”

18.3 Who should carry out the enquiry?

Once the decision has been made that a safeguarding concern should progress to a S42 Enquiry then the decision maker within the Adult Protection team will decide which agency is best placed to carry it out. Although the local authority is the lead agency for making enquiries, it may require others to undertake them. The specific circumstances will often determine who is the right person to begin an enquiry.

This is the extract from the statutory guidance on who should undertake the enquiry. Local decision making between the Adult Protection team and other agencies will still take place to agree who will carry out the enquiry.

The employer should investigate any concern (and provide any additional support that the adult may need) unless there is compelling reason why it is inappropriate or unsafe to do this. For example, this could be a serious conflict of interest on the part of the employer, concerns having been raised about non-effective past enquiries or serious, multiple concerns, or a matter that requires investigation by the police.

If the enquiry is undertaken by an agency other than the Adult Protection team the quality of the enquiry will need to be checked. The Adult Protection Team in its lead and coordinating role, should assure itself that the enquiry satisfies under its duty under Section 42 to decide what action (if any) is necessary to help and protect the adult and by whom, and to ensure that such action is taken when necessary. In this role if the Adult Protection team has asked someone else to make enquiries, it is able to challenge the body making the enquiry if it considers that the process and/or outcome is unsatisfactory.

The Adult Protection Team will make enquiries when:

- There is a serious conflict of interest on the part of the employer
- Concerns having been raised about non-effective past enquiries
- The incident is serious
- The incident involves multiple concerns
- The incident requires investigation by the police

Once the enquiry has achieved the desired outcome of the adult at risk then the S42 Enquiry is complete. The enquiry should follow the principles of Making Safeguarding Personal.

Making Safeguarding Personal (MSP) is about having conversations with people about how we might respond in safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

It is about seeing people as experts in their own lives and working alongside them with the aim of enabling them to reach better resolution of their circumstances and recovery. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conservations supported by a process.

MSP means any concern should be person-led and outcome-focussed. We all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised.

If the outcomes are not achieved the enquiry must continue. The flow chart shows the pathway the enquiry will take.

Examples of outcomes are:

- Criminal prosecution of the person who caused the abuse or risk
- Assessment of care and support needs
- Review of care and support needs
- Moved to a different location
- Management of access to the person who caused the risk or abuse

- Management of access to finances
- Regular reviews
- Referred for counselling
- Referred for training

The outcome of the enquiry will be fed back to all relevant parties with an outcome meeting which will be coordinated by the Adult Protection Team.

Anyone alleged to have been victims or perpetrators of abuse have the right to contest or appeal against the findings that abuse had or has not occurred and the nature of that abuse.

Concerns or disagreements regarding the decision whether or not to investigate a safeguarding concern, the type of investigation decided upon, the performance any individual or the provision/non provision of a service are outside the scope of this procedure and should be addressed first with the relevant individual and then via the complaints procedure of that individual's employing agency.

Disagreements regarding any safeguarding plan developed are also outside the scope of this procedure and should be addressed through the review process.

The full criteria for contesting decisions are:

- The complainant must be the alleged victim, perpetrator or their representative
- The only decisions which may be contested are that abuse did or did not take place and the nature of that abuse
- The review of the decision making process must take place within the following parameters:
- Whether the decision making process was fair and objective
- Whether the decision making process had all the relevant information available to it and whether due consideration was given to it
- Whether failure to meet these criteria materially impacted on the decision made

19 Contesting the decision of the Safeguarding Manager

Where the disputed decision has been made by the Adult Protection Team Manager, the complainant should ask him/her in writing to review that decision setting out why they disagree with the decision made.

If the dispute does not meet the criteria the Adult Protection Team Manager should not review but should direct the complaint to the complaints procedure of the relevant organisation. If the complaint does meet the criteria, the Safeguarding Manager should then:

- Review the investigation report
- Consider whether additional investigation is required
- Review their decision making process according to the criteria set out above
- Discuss the case within supervision to obtain independent overview

The Adult Protection Manager should respond in writing within 20 days setting out the findings of the review and explaining their right of appeal to the North Lincolnshire Council Safeguarding Adults Board.

If the complainant is not satisfied, they should write to the Independent Chair of the Safeguarding Adults Board within 10 days of receiving the response setting out the reasons why they disagree with the response.

The Independent Chair will appoint a member of the Safeguarding Adults Board to review the disputed decision. The appointed officer will respond to the complainant within 20 days setting out their findings. If they have overturned the decision of the Safeguarding Manager, the protection planning will need to be repeated in the light of the new information.

19.1 Contesting the decision of an Outcome Meeting (Case Conference)

The complainant should write to the Independent Chair of the Safeguarding Adults Board within 10 days of the outcome meeting setting out why they think the wrong decision was made. Applications should be made to the Independent Chair North Lincolnshire Safeguarding Adults Board. If the dispute does not meet the criteria the Independent Chair should not review but should direct the complainant to the complaints procedure of the relevant organisation.

If the complaint does meet the criteria, the Independent Chair will acknowledge receipt within 10 days. Usually, the chair will review the case but where there is benefit to the decision making process she/he may convene a panel comprising of him/herself and at least two other Board Members. These members must not have had any previous or current management responsibilities for any aspect of the case or anyone involved in it. To facilitate resolution, the Independent Chair may ask for additional investigations to take place prior to any outcome appeal meeting and review relevant documents.

If, following the above process the Independent Chair feels there are grounds, she/he will convene an outcome review meeting. She/he should invite all of the people present at the original outcome meeting, the complainant and anyone else she/he deems appropriate. The alleged victim and perpetrator should always be invited, although each may be asked absent themselves from part of the meeting at the discretion of the Independent Chair to enable each to participate fully. The appeal may be heard by the Independent Chair alone or by the panel who considered the grounds for the meeting. This is at the discretion of the Independent Chair.

The outcome review meeting can only consider whether the decisions regarding whether or not abuse took place and the nature of that abuse were justified although if there are learning points for anyone involved they must be shared with the agencies involved. If these learning points give grounds for complaint against any individual or agency, the complainant should be directed to the complaints manager of the relevant agency. If the outcome meeting overturns the original findings, then the safeguarding plan must be reviewed.

20 Safeguarding Plan

The safeguarding plan is developed at the outcome meeting to address any ongoing risks to the care and support needs adult.

Safeguarding Plans should:

- Identify actions, roles and timescales
- Take account of the wishes of the individual
- Detail arrangements for monitoring and review
- Identify factors that may increase the identified risk and give contingency plans in such circumstances

20.1 Review of the Safeguarding Plan

A timescale for a review of any safeguarding plan will be agreed at the outcome meeting. It will be recorded and will take place within three months and thereafter yearly as part of routine reviews, until the safeguarding plan is completed. Any change in circumstances will result in appropriate changes being made to the safeguarding plan; these changes will be made by the person identified to review the plan.

Recording and Monitoring

The Adult Protection Team ensures that full minutes and comprehensive records are kept of the outcomes of any Section 42 Enquiry. The Adult Protection Team records all safeguarding concerns and enquiry details onto the council's social care record system; an annual report is submitted by the council to the Department of Health for the SAR National Data Report.

Chapter 5

Complaints and Appeals

21 Complaints Procedures and Safeguarding Adults

21.1 Organisations providing health or social care services to care and support needs people should have their own internal Complaints Procedure. This includes the organisations that have signed up to the North Lincolnshire Safeguarding Adults Policy and Procedures or who are providers of contracted or accredited services.

21.2 The use of a Complaints Procedure should never replace the use of the Safeguarding Adults Policy and Procedures as a method of managing an Investigation into the abuse of an adult with care and support needs.

21.3 If an allegation that a care and support needs person has been abused or is at risk of being abused is reported to an organisation in the form of a complaint, the allegation should be referred immediately to the Safeguarding Adults Procedure.

21.4 If it is decided that the matter is not one to be addressed under the safeguarding Adults Procedure then consideration should be given as to whether the issues should be addressed as a complaint by the relevant organisation.

21.5 Carrying out the Safeguarding Adults Enquiry should always take precedence over the investigation of a complaint. Carrying out an investigation under the Complaints Procedure may have to be delayed until the Safeguarding Adults Enquiry has been completed. This is particularly important if the Police are carrying out an investigation.

21.6 Wherever possible the need to interview someone twice should be avoided and people who are interviewed should be clear under which Procedure they are being interviewed.

21.7 If there are a series of complaints about the abuse of several users of the service the Adult Protection Team will need to consider whether they need to deal with the matter as a Larger Scale Investigation.

22 Appeals Protocol within Safeguarding Adults

This protocol outlines:

- The circumstances in which appeals about the management of adult safeguarding outcome meeting and/or decisions about the outcome of a Section 42 Enquiry can be made.
- How such appeals are to be resolved.
- Who can appeal.

22.1 When can an appeal be made?

Appeals can be made in the following circumstances:

- The multi-agency Safeguarding outcome meeting has not been run properly and in accordance with North Lincolnshire Safeguarding Adults Procedures and/or
- The plans made at the multi-agency Safeguarding Adults outcome meeting are not in the best interests of the care and support needs adult.
- When an agency disagree with the recommendations of the outcome meeting outcome.

22.2 Who can use this procedure?

- Care and support needs adults, carers and their advocates.
- A professional attending the outcome meeting.
- A person or organisation who is affected by the recommendations of the outcome meeting.

22.3 How can the procedure be implemented?

Anyone who wishes to challenge the recommendation of the outcome meeting should put this request in writing within 21 working days of the meeting taking place. They must indicate which of the above appeal criteria they believe applies to the case in question. They should send the written appeal to c/o Safeguarding Adults Board Manager, Church Square House, 30-40 High Street, Scunthorpe, North Lincolnshire, DN15 6NL.

On receipt of the request for an appeal the Independent Chair Person of the North Lincolnshire Safeguarding Adults Board will:

- Review all of the individual written agency reports that were submitted to the adult safeguarding conference together with the outcome meeting.
- Where necessary, contact the complainant to clarify on what basis the appeal is being made.
- In all appeals the Independent Chair Person will interview other participants in the outcome meeting to clarify specific issues.
- In all appeals the Independent Chair Person will consult with the Chair Person of the outcome meeting and the Adult Protection Team Manager.
- If necessary the Independent Chair Person will arrange for the complainant to be interviewed by an agency colleague who is outside of the case management process of the case.

22.4 Outcome of an Appeal

The Independent Chair Person will determine within 28 days of the receipt of the appeal whether it is upheld and write to the complainant.

If the Appeal is upheld the Independent Chair Person will request that the Safeguarding Adults outcome meeting is reconvened as quickly as possible to reconsider their decision

and will inform the Chair Person of the outcome meeting of the reasons why the appeal was upheld.

The Independent Chair Person will, in addition offer advice to the outcome meeting in reconsidering their previous decisions and about whether the reconvened outcome meeting should be chaired an alternative person.

If the appeal is not upheld, the Independent Chair Person will write to the complainant confirming that the original decision will stand. The Independent Chair Person will ensure that the Chair Person of the original outcome meeting, and the other attendees, are aware that the appeal has been made and turned down.

22.5 Summary of Timescales

Time limit for appeals: within 21 days of Safeguarding Adults outcome meeting
Time limit for response to appeals: within 28 days of appeal.

Any disagreement or complaint about:

- Case management during the investigation of Safeguarding Adults concerns leading to outcome meeting; or
- Individual agencies and the provision or non-provision of services.

Should be directed to the agency concerned for consideration under their own complaints procedure or the North Lincolnshire Council complaints officer.

Email: complaints@northlincs.gov.uk

Telephone: 01724 296426

Address: Representations Manager, Hewson House, Station Road, Brigg DN20 8XJ

Chapter 6

Legal and Policy Context of Safeguarding Adults Work

23 Legal and Policy Context of Safeguarding Adults Work

There are specific provisions within The Care Act 2014 relating to safeguarding (Sections 42-47).

Section 42 provides that there is a duty upon Local Authorities where it has reasonable cause to suspect that an adult in its area (which is wider than limited to an adult who is ordinarily resident in its area) has needs for care and support (whether or not those needs are met by a Local Authority) and that adult is experiencing or is at risk of abuse and neglect and, as a result of those needs, they are unable to protect themselves against such abuse or neglect or the risk of it. The legislation specifically provides that abuse includes financial abuse. In those circumstances, section 42 provides that a Local Authority must make appropriate enquiries to decide whether action should be taken and, if so what and by whom.

Section 43 provides for the establishment of Adult Safeguarding Boards who are to help and protect those adults who are experiencing abuse or neglect or at risk of the same. The Adult Safeguarding Board is made up of representatives of statutory and voluntary bodies and other individuals. Prior to implementation of The Care Act 2014 such boards were not enshrined in legislation only statutory guidance. An Adult Safeguarding Board may lawfully do anything which is necessary and desirable to achieve its objectives. This is achieved through its membership. In addition an Adult Safeguarding Board has responsibility for conducting Safeguarding Adult Reviews in appropriate circumstances.

The Care Act section 45 makes specific provisions imposing obligations upon members of The Adult Safeguarding Board and others to share information.

There is specific provision (section 47) relating to the protection of property where an adult is provided with care and treatment away from their home. It is my understanding that whilst The Care Act provides for functions to be delegated by a Local Authority, the role and responsibility of the Local Authority in respect of safeguarding cannot be totally delegated as it retains ultimate responsibility for how the obligations relating to safeguarding are undertaken.

North Lincolnshire Safeguarding Adults Board

Learning and Development Framework

The North Lincolnshire Safeguarding Adult Board
Learning and Development Framework

Introduction

The Care Act requires Safeguarding Adult Boards to undertake Safeguarding Adult Reviews as appropriate and the SAB is free to determine how the review should be undertaken.

The purpose of this document is to identify how Safeguarding Adult Reviews will be undertaken in adherence with the statutory guidance 2014.

The Principles that underpin Safeguarding Adult Reviews

The following principles underpin Safeguarding Adult Reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of care and support needs adults, identifying opportunities to draw on what works and promotes good practice;
- There should be a no blame culture which permeates all learning and development including safeguarding adult reviews
- Learning is a dynamic, continuous process and knowledge does not remain static
- Professionals and organisations will use evidence based, research to inform their practice
- Knowledge should be shared across agencies to build and enhance multi agency working families.
- Knowledge and information will be shared to build understanding and improve professional practice in order to improve outcomes for care and support needs adults and their families/ carers.
- Professional development is an ongoing process from induction onwards

When a SAR must be undertaken

- A SAB must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

- The SAB must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect, where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life as a result of abuse or neglect. SAB's are free to arrange for a SAR in any other situations involving an adult in its area with or without care and support needs.

The Purpose of a Safeguarding Adult Review

The purpose of a SAR is:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.
- To review the effectiveness of procedures (Both multi-agency and those of individual organisations)
- To inform and improve local inter-agency practice
- To improve practice by acting on learning (developing best practice)
- To prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action[1].

It is acknowledged that all agencies will have their own internal or statutory review procedures to investigate serious incidents and untoward Incidents[2]. This procedure is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.
SARs and other case reviews should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard care and support needs adults;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

Referral of cases for a Safeguarding Adult Review

The North Lincolnshire Safeguarding Adult Review Group has the delegated responsibility for considering cases which may warrant a review.

A request can be made for a case to be considered by the SAR group in the following circumstances:

- The adult has died as a result of abuse and neglect whether known or suspected and
- There is a concern that partner agencies could have worked more effectively to protect the adult.

In addition

[1] The Secretary of State also has authority under the Local Authority Social Services Act 1970 to cause an inquiry to be held where he considers it advisable
[2] An investigation within a healthcare setting

Where the adult is still alive but the SAB knows or suspects that the adult experienced serious abuse or neglect, and the individual would have been likely to have died but for an intervention or has suffered permanent harm or reduced capacity or quality of life as a result of the abuse or neglect.

Any agency or individual can bring a case for consideration by the SAR group using the template in appendix 1, however unless a referral is made under whistle blowing procedures http://www.northlincs.gov.uk/your-council/about-your-council/policy-and-budgets/audit-at-north-lincolnshire/

the case must be discussed by the agencies Designated Safeguarding Manager.

A referral made under whistle blowing procedures will come directly to the SAR Group, by sending the form see appendix 1 to the Safeguarding Adult Board Manager at Church Square House, PO Box 42, Scunthorpe, North Lincolnshire DN15 6XQ

The SAR group will consider the case referred, identify if further information is required to support them making a recommendation to the Chair of the SAB. The SAR Group will also consider the most appropriate methodology for undertaking a SAR and advise the Independent Chair of this.

The decision making regarding whether a SAR should be undertaken rests with the Independent Chair of the SAB and the SAB itself.

The SAR Group will record their recommendation regarding the specific case discussed in the decision making proforma in appendix 2.

Once the Chair has made the decision on whether a SAR should be held or not they will write to the Chair of the SAR group to inform them of the decision and action to be taken.

Each member of the SAB must co-operate with and contribute to a SAR in line with the duties set out in the Care Act 2014.

Involvement of the adult, family and friends

The SAB is required to ensure that the individual (who is still alive) family/ friends are invited to contribute to a SAR and where necessary an adult should be provided with an independent advocate to support their involvement. The involvement of an adult should be carefully supported ensuring that they have access to information about the review to be undertaken, how it will be undertaken and how they can contribute to it. In some cases it may be helpful to communicate with the person who caused the abuse or neglect.

The role of the Safeguarding Adult Review Group

The membership of the SAR Group is determined by the Safeguarding Adult Board. The SAR Group will meet at least annually and if circumstance necessitates sooner to consider a case that has been referred to the Group. The Group will decide, based on the information provided that the case meets the criteria outlined in section 1 above. If further information is required to inform the decision this will be provided to the Group within a timescale outlined.

The roles and responsibilities of Safeguarding Adult Review Group are outlined in the Terms of Reference for the Group.

If the Group agree a case has met the criteria to undertake a review, as outlined on page 63 the Chair of the SAR Group will formally write to the Independent Chair of the Safeguarding Adults Board and enclose a copy of the decision making proforma (in appendix 3).

The Independent Chair of the SAB will write to the Chair of the SAR Group outlining their decision.

There can be four outcomes to a referral made to consider whether a case meets the criteria for a SAR:

- A SAR is to be commissioned as the criteria has been met and the methodology for undertaking the SAR is determined and agreed in the terms of reference for the SAR.
- The criteria in section 1 has not been met but the SAB considers that a review of the case should be undertaken and specifies the manner in which the review should be undertaken.
- The criteria has not been met and single agency action is required.
- No further action is required at this time.

The outcome of a referral will be put in writing by the Independent Chair of the SAB to the Chair of the SAR Group. The Independent Chair will also write to the referring agency to inform them of the decision.

Links with other reviews

1) Domestic Homicide Reviews

Where victims of domestic homicide are aged between 16 and 18 there are separate requirements in statutory guidance for both a Safeguarding Adult Review and a domestic homicide review.

Where there are possible grounds for both a SAR and a Domestic Homicide Review then a decision should be made at the outset by the two decision makers; the SAB and the Safer Neighbourhoods Board, as to which process is to lead and who is to chair with a final joint report being taken to both Boards.

Any SAR will need to take account of a coroner's inquest and, or, any criminal investigation related to the case, including disclosure issues, to ensure that any relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the chair of the SAR to ensure that contact is made with the chair of any other parallel process.

Where there is a related criminal investigation and prosecution, early discussions and agreements with the relevant criminal justice agencies will need to be held to ensure that the review does not prejudice these proceedings. The Chair of the SAR will contact the Senior Investigating Officer to agree decision making, shared information and inform on key dates in the investigation, such as bail dates, Section 51 and PCMH (Plea and Direction Hearing). Included in the discussion will be a decision that the review will not be carried out or finalised

until all investigations are concluded. However, if new evidence is identified, which may have a bearing on these proceedings; the SIO will be updated immediately by the SAR Chair. The review body will need to consider if any of the recommendations identified would jeopardise the proceedings if they were to be taken forward prior to the conclusion of the judicial process. Nevertheless, all decisions should be made based on the circumstances of each individual case and at a local level and through consultation.

In setting up a SAR, the SAB should consider how the process can dovetail with any other relevant investigations that are running in parallel. If there are combined reviews, the terms of reference should make it clear that both procedures are fully addressed and specific actions included.

Domestic Homicide Reviews should be undertaken in accordance with The Home Office Domestic Homicide Review Guidance which can be accessed at:

> https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf

Where a child has been witness to, or involved in the incident the Local Safeguarding Children's Board (LSCB) procedures should be followed. Actions are likely to include a referral to Children's Social Work referral management to safeguard the child. LSCB procedures can be found at www.northlincs.gov.uk/lscb

Agency involvement in Safeguarding Adult Reviews

Agencies are statutorily required to contribute to SAR's in an open, honest and transparent manner.

North Lincolnshire Safeguarding Adults Board is the body that commissions a SAR, through an appointed group.

The Independent Chair of the SAB will appoint a person to lead and Chair the SAR who is independent of the case under review and of the organisations who actions are being reviewed.

The Independent Chair of the SAB will formally request Chief Officers of involved and relevant agencies to nominate a representative who is independent of the case to sit on the SAR (case specific) Group. The nominated representative must have the appropriate seniority; skills; knowledge of safeguarding care and support needs adults, and experience.

The Independent Chair of the SAB will commission/ identify an overview writer to complete the SAR report and where necessary the Executive Summary.

The SAR Group will draw up the terms of reference for the review to be undertaken and these will be considered and ratified by the SAR (case specific) group when it meets with the Chair who has been commissioned to lead the review.

The terms of reference for the Safeguarding Adult Review will be developed considering:

- What appear to be the most important issues to address in identifying the learning from this specific case?
- How can the relevant information best be obtained and analysed, including, for instance, information on the mental health of relevant adults?
- When should the SAR start, and by what date should it be completed, bearing in mind the timescales for completion set out below?
- Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the Overview Report?
- Over what time period should events in the case? be reviewed, i.e. how far back should enquiries extend and what is the cut-off point?
- What family history / background information will help better to understand the recent past and the present?
- How should the care and support needs adult (where the review does not involve a death), carers and family members contribute to the SAR, and who should be responsible for facilitating their involvement?
- How will they be involved and contribute throughout the overall process?
- Are there any specific considerations around ethnicity, religion, diversity or equalities issues that may require special consideration?
- Which organisations and professionals should be asked to submit reports or otherwise contribute to the SAR?
- Who will make the link with relevant interests outside the main statutory organisations, for example independent professionals, independent healthcare providers or voluntary organisations?
- What should be the respective roles and responsibilities of the different LSABs with an interest?
- Will the LSAB need to obtain independent legal advice about any aspect of the proposed SAR?
- Who should be appointed as the independent author for the overview report?
- Expert advice may be sought to help understand crucial aspects of the case?
- Will the case give rise to other parallel investigations of practice, for example, into the health or social care provided, or multi-disciplinary suicide reviews, a domestic homicide review, a Prisons and Probation Ombudsman (PPO), Fatal Incidents Investigation where the care and support needs adult has died in a custodial setting, or a Serious Further Offence (SFO) or MAPPA Safeguarding Review (MSCR) process where offenders are charged with serious further offences whilst subject to statutory supervision? And if so, how can a coordinated or jointly commissioned review process address all the relevant questions that need to be asked in the most effective way and with minimal delay?
- Arrangements should be agreed locally on how a NHS Serious Untoward Incident (SUI) investigation into the provision of healthcare should be coordinated with a SAR
- How will the SAR terms of reference and processes compliment other types of reviews – for example, for homicide, mental health or prisons?
- How should the review process take account of a coroner's inquiry, any criminal investigations (if relevant), and family or other civil court proceedings related to the case?

- Identify clear lines of communication with the coroner and/or the Crown Prosecution Service (CPS) and to ensure that relevant information can be shared without incurring significant delay in the review process?
- How should the review process take account of relevant lessons learned from research and from SARs which have been undertaken by the LSAB?
- How should any family, public and media interest be managed before, during and after the SAR? In particular, how should surviving care and support needs adults and family members be informed of the findings of the SAR?

Due consideration should always be given to the impact of any discussions on criminal proceedings. Before any such cases are discussed appropriate liaison should take place with relevant parties such as the Crown Prosecution Service and Senior Investigating Officer.

The scope and timescale of the review will be agreed between the Chair and the Safeguarding Adults Review Group. The outcome of the review will be reported to the Board.

When cross border circumstances arise, the Independent Chair of the Board should contact the Independent Chair of the relevant authority to agree a local process. Primacy will be established and shared information processes identified.

The CQC and Safeguarding Adult Reviews

"The CQC recognises they may have a role to play in SAR's and the learning that arises from them, particularly where they relate to a service regulated by CQC. However, CQC is not routinely involved in all SARs and hold no decision-making authority within this process. Local safeguarding partnerships will notify CQC of the instigation of a SAR when it relates to a regulated service and of their outcomes and associated action plans".

CQC's attendance at the first panel meeting of a SAR can be particularly beneficial for all parties, even where there is no further participation required from CQC. It enables a shared understanding of the role of CQC and what part we can play in the proceedings. It can establish clear, realistic expectations of our contribution to the process.

When a SAR is initiated, CQC where appropriate, will undertake a separate management review of their involvement with the case. The aim of a management review is to openly and critically examine an organisation's practice to see if there are any changes or improvements required, or opportunities for learning.

Methodological approaches for conducting a Safeguarding Adult Review

SAB's are free to determine the most appropriate method by which to undertake a SAR, however it must be proportionate to the specific circumstances of the case. The most suitable method will normally be the one which will provide the maximum amount of learning.

The different methodologies that can be chosen are:

Systems Review Methodology

This methodology is designed to understand why this did not go well, why professionals took the action they did and made the decision they did at the time. It is designed to understand the situation from their perspective at the time in order to avoid hindsight bias. In North Lincolnshire we have a specific local model developed which can be implemented. This is on appendix 1.

Traditional approach as per Safeguarding Adult Reviews

This methodology uses Individual Management Review Reports from agencies as a means of enabling organizations to reflect and critically analyse their involvement with a case. The method is very fact based and considers what people did, and when. The North Lincolnshire model for this approach is contained on appendix 1.

Root Cause Analysis

RCA is a method used to uncover the underlying causes of incidents. It looks beyond the individual and seeks to understand the underlying causes and environmental context in which the incident happened. It is designed to identify the sequence of events working back from the incident itself and identifies a range of factors which contributed to the incident.

Significant Event Analysis

This method brings together managers and or practitioners to consider significant events within a case and analyse together what went well and what could have been done differently. Its focus is on learning which can lead to future improvements.

In determining the methodological approach to be used the SAR will consider the facts and evidence of the case, the level and severity of harm, the complexity of the issues, potential for learning, and where the learning needs to be particularly applied.

Learning from Reviews

The SAB is committed to a culture of promoting learning and improvement. The SAR process forms part of a wider Learning and Improvement Framework. As part of the SAR process how the learning will be disseminated will be agreed in the terms of reference for the SAR. Any review which results in an action plan will be monitored by the SAB. The SAB training strategy and programme will be updated and reflect areas of learning for multi agencies identified from SAR's.

Who should be involved in the Safeguarding Adult Review?

The initial scoping of the SAR should identify those who should contribute, although it may emerge as further information becomes available, that the involvement of others such as those providing specialist adult services would be useful.

Designated safeguarding health professionals on behalf of health commissioners (NLCCG and NHS England) should review and evaluate the practice of all involved health

professionals. This may involve reviewing the involvement of individual practitioners and NHS Trusts and advising named professionals and managers compiling reports for the review. Irrespective of the methodology used for the SAR, the Designated health professionals will need to produce an integrated health chronology and a health overview report focusing on how health organisations have interacted together. The format of this report will be subject to agreement with the Area Team of NHS England. This may generate additional recommendations for health organisations. The health overview report will constitute an IMR for health commissioners. Designated safeguarding health professionals also have an important role in providing guidance on how to balance confidentiality and disclosure issues to ensure an objective, just and thorough approach to identifying lessons in the IMR. If the designated health professional(s) have been clinically involved in the case the CCG should seek advice and help from another CCG designated professional as necessary.

Disclosure of information

The process of conducting an SAR requires access to records relevant to the care and support needs adult such as those from health bodies. The public interest served by this process warrants full disclosure of all relevant information within the adult's own records. While in most cases there will be a public interest in disclosing this information the record holder should ensure that any information they disclose is both necessary and proportionate. The reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS commissioned care, whether provided under the NHS or in the independent or voluntary sector.

It is crucial that those leading the review have access to all relevant documentation and where necessary individual professionals.

Security of Information

Where a case is being considered for a SAR, agencies to whom the care and support needs adult is known should take steps to secure records pertaining to the adult. This may include freezing files or taking copies of the files up to and including the date of notification. Each agency is expected to have its own internal procedure for securing files.

When it is known that a case is being considered for a SAR each agency should secure the records relating to the case to guard against loss or interference. Once it is decided that a SAR will be undertaken, individual organisations, having secured their case records promptly, should begin to quickly draw up a chronology of their involvement with the care and support needs adult.

All information will be transferred securely using Government Secure Infrastructure connections, encryption and/or documents that are password protected. All organisations will need to be mindful of their own and other partner agencies policies on data security.

Timescale for SAR completion

The SAB should aim for completion of a SAR within six months of initiating it. If this is not possible, (for example, because of potential prejudice to related court proceedings), every

effort should be made while the SAR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action.

SAB action on receiving the safeguarding adults review report

The SAR Group on behalf of the SAB should quality assure the final SAR Report.
The Board should approve the final SAR report and:

- Reassure itself on arrangements to provide feedback and debriefing to staff and the media as appropriate;
- Consider how to disseminate the key findings to relevant interested parties;
- Publish the overview report
- Implement those actions for which the SAB has lead responsibility and monitor the timely implementation of the SAR action plan;

When compiling and preparing to publish reports, the SAB should consider carefully how best to manage the impact of publication on family members and others affected by the case. SAB's must comply with the Data Protection Act 1998 in relation to SARs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders.

Methodological approaches:

1) Systems Review methodology

North Lincolnshire has developed a local model using the principles and ethos of the SCIE model, the reflections from the Munro Review into Child Protection and the "New View of Human Error" as proposed by Sydney Dekker in "The Field Guide to Understanding Human Error".

The New View on Human Error[3]

We have two options in making sense of human error following accidents, incidents or mishaps. Dekker proposes that the choice made determines the focus, questions, answers and ultimately the success of your efforts, as well as the potential for progress on safety in organisations and systems:

- You can see human error as **the cause of a mishap**. In this case "human error", under whatever label – loss of situation awareness, procedural violation, regulatory shortcomings, managerial deficiencies – is the conclusion of your efforts to understand error.
- You can see human error as **the symptom of deeper trouble**. In this case, human error is the starting point for your efforts. Finding "errors" is only the beginning. You will probe how human error is systematically connected to features of people's tools, tasks and operational/organisational environment.

[3] From Preface of Dekker, S (2006) The Field Guide to Understanding of Human Error pp x-xii

The first is the Old View and focuses on the concept that unreliable people (Bad Apples) undermine basically safe systems. The purpose of investigations is to identify people's shortcomings and failings. And in efforts to improve safety, we must make sure people do not contribute to trouble again (so make more rules, more "automation", more reprimands (blame).

The second is the New View and seeks to explain how human error is a symptom of trouble (engineered, organised, social etc.) deeper inside the system, and that efforts to understand error begin with seeing how people try to create safety through their practice of reconciling multiple and often competing goals (safety, resource, performance targets, organisational/service priorities) in a complex dynamic setting. This New View recognises that people do not come to work to do a bad job. Safety in complex systems is not a result of getting rid of people or reducing their degrees of freedom. Safety in complex systems is **created by people through practice** – at all levels in organisations and systems. It is only people who have the flexibility to hold together the patchwork of tools, technologies and processes and do the work in environments where irreconcilable goals compete for their attention.

The Old View of human error on what goes wrong	**The New View of human error on what goes wrong**
Human error is a cause of trouble	Human error is a symptom of trouble deeper inside a system
To explain failure, you must seek failures (errors, violations, incompetence, mistakes)	To explain failure, do not try to find where people went wrong.
You must find people's inaccurate assessments, wrong decisions; bad judgements	Instead, find how people's assessments and actions made sense at the time, given the circumstances that surrounded them.
The Old View of human error on how to make it right	**The New View of human error on how to make it right**
Complex systems are basically safe	Complex systems are not basically safe
Unreliable, erratic humans undermine defences, rules and regulations	Complex systems are trade-offs between multiple irreconcilable goals (e.g. safety and efficiency)
To make systems safer, restrict the human contribution by tighter procedures, automation, supervision	People have to create safety through practice at all levels of an organisation

Principles that underpin the North Lincolnshire System Review Model

'Systems are not basically safe. People in them have to create safety'

- The approach the review team will take will be to avoid hindsight bias.
- The System Review Model rejects the person centred approach to human error.
- Errors are not the cause of trouble; they are consequences of symptoms.

- The Review will attain individuals 'local rationality' – what sense practitioners and families made of the situation at point(s) in the process.
- People are a source of safety.
- Human error is not the conclusion of an investigation. It is the starting point.
- Sources of error are structural not personal.
- The model will be used to provide a window of opportunity to review a system and the experiences of the practitioners in that system.

Key Features of the North Lincolnshire System Review Model

- Front line staff who were/are working with the child/family are actively involved in the review, they provide a source of data and contribute to the analysis.
- There will be a multi-agency review team who will gather the necessary data.
- There will be no lengthy Individual Management Review Reports.
- Human error will be taken as the starting point not the conclusion.
- Analysis will focus upon 'why' incidents occurred and where in system the causal factors lie.
- The methodology used will be collaborative participation.
- The review will operate a systemic focus, whereby the model sees accidents as emerging from interactions between components and processes rather than failures within them.
- Report produced will focus on themes identified.
- Recommendations made will be SMARTER.

Selecting the Review Team

- Following approval by the Independent Chair of the SAB the Safeguarding Adults Review Group will establish a Review Team.
- The Review Team will be made up of 2 Lead Reviewers and other members of the SAR Group.
- The Review Team will meet and develop the terms of reference for the review.

<u>Principles:</u>

- A systems review requires a team not just one person.
- Knowledge of the key professions involved can be beneficial.
- Outsider status can help workers engage openly in the process.

Lead Reviewers

2 lead reviewers will be identified.

The lead reviewers will not have been directly involved in the case. If all agencies have had significant contact then it may be necessary to identify lead reviewer(s) who are independent of North Lincolnshire services. The identification of the lead reviewers will also need to take account of the perception of family members, e.g.do the circumstances requiring review need an independent lead reviewer for the family to feel valid learning can be achieved.

Commitment

The work required by the lead reviewers will be significant. If a lead reviewer is identified from a local agency:

- The employing organisation will need to be prepared to release the professional from some aspects of day-to-day practice.

- The lead reviewers will need to identify at the beginning of the process, all key dates/events which need to be achieved, and ensure that protected time for meetings, collaboration with fellow lead reviewers, and report writing is identified for the whole process.
- Protected time assigned for the purpose of completing this review cannot be cancelled by the reviewer, reviewer's employing organisation, or for multi-agency activity except in very exceptional circumstances.

Experience

The two lead reviewers will need to have:

- Proven ability to critically analyse information.
- Ability to distil key findings from a large amount of information.
- Ability to present findings in a comprehensible form to ensure that readers can understand the relevance and significance of the conclusions, particularly where remedial actions are required.
- Ability to present the findings of the report to the SAB, or any other party that is required.
- Experience of involvement in Safeguarding Adults Reviews or lower level reviews.
- Evidence of experience of working in safeguarding of care and support needs adults field in a senior capacity.
- Significant experience of multi-agency working.
- Experience of chairing complex multi-agency meetings.

Review Panel

At least two other reviewers will be identified to support the lead reviewers. The experience of these reviewers may be less, but they will be required to assist the lead reviewers in the recognition of issues in other agencies, and therefore should be from different organisations/professional backgrounds to the lead reviewers.

As with the guidelines in respect to the commitment of the Lead Reviewers, the members of the Review Panel need to have securely protected time to contribute to the review.

Identifying Key lines of Enquiry and setting Terms of Reference

The Terms of Reference for the review will be set buy the Lead Reviewers, and Review Panel. Other professionals may also be used, as appropriate, dependent on the case.

The information shared at the SAR group meeting where the decision was taken to complete the Systems Review will inform the key lines of enquiry, and questions which the Systems Review should address, and the questions which may need answering.

The key questions could arise from:

- Places where people did (or could have done) something.
- Places where processes did (or could have done) something.

- Short episodes where people or process they managed contributed critically to the direction of events and/or the outcome that resulted.

The time period reviewed will be dependent on the lines of enquiry or key questions. It is highly likely, but not definite that the review will explore a period of time leading up to the incident which precipitated the referral to the SAR group. The review will move away from the 'shopping bag approach' which puts all incidents/ cues into a bag, as this presents information into 'one big glob of overwhelming evidence' and does not assist in trying to understand how people made sense of the situation at the time.

In some circumstances, exploration of a theme or themes over a longer period of time will be identified in order to get a window on the system and to gain some understanding about what sense practitioners made of the context of work they were involved in i.e. the perspective from inside the tunnel.

'The perspective from inside of the tunnel'

This is the point of view of people in the unfolding situation. To them the outcome was not known (or they would have done something else). They contributed to the direction of the sequence of events on the basis of what they saw on the inside of the unfolding situation. To understand human error you need to attain this perspective',

The review will consider:

- How the situation looked to those involved at the time
- How did the situation unfold around them: what cues did they get when?
- What goals were they likely pursuing at that time?

The outcome of a Systems review is rather than to make sense of the situation in hindsight we are trying to understand why things made sense to the people involved at the time and they then took the actions they did.

The Terms of Reference will be sent to the SAB Independent Chair for approval.

Identifying who should be involved

Having identified the Terms of Reference, the Lead Reviewer(s) will write to each organisation identified as being crucial to addressing the key lines of enquiry or questions. Ideally, all personnel involved in the case, or part of the case, under review will be involved in the review process. This includes both workers and the members of the family themselves.

Ideally, all personnel from whatever sector and/or agency and at all levels within organisations will be involved in the review. However, as the majority of cases run over a significant period of time, this will often not be realistic. Consequently, judgement will be required as to whose roles and contributions will be most significant. This will not necessarily

be self-evident at the beginning of the review, but instead may emerge gradually over time. It will be important to try to identify staff who were seen as key by members of the family as well as by professionals.

Given their management roles and responsibilities related, for example, to supervision, budgets and performance indicators, it will be important to include significant first-line managers and not only the staff who have worked with or had direct contact with the family.

Family involvement

In order for a clear understanding of the "system", it is necessary to consider the appropriate involvement of family members in the review. Without family members key perspectives will be missed.

Careful consideration needs to be given to how family are involved in the review process. Identifying key professionals who have a continuing relationship with the family, to work in collaboration with the Lead Reviewers to involve the family at an appropriate level should be explored.

Preparing participants

The preparation of participants is the responsibility of agencies with support from the SAB Manager/ Chair of SAR group and lead reviewers.

Participants at all levels will receive an introductory letter explaining the process.

Lead reviewers will meet with agency leads to explain Systems Review process, and answer questions for those who will then be expected to prepare operational managers and front-line practitioners.

It is vital that participants are given a thorough introduction to a systems approach before the review begins. Otherwise it would be difficult for them to participate actively.

The beginning of the Learning Day will be an opportunity to refresh participant understanding of the process, and answer any outstanding questions. The aim of this is to ensure that they understand the aims of the approach, what it entails and the part they are being asked to play. It also serves to demonstrate in a very tangible fashion the nature of the relationships and dialogue with participants that the review team wants to develop. It can also serve to foster the beginning of a group identity and, therefore, the possibility of joint ownership, across agencies, of the review process and findings.

Confidentiality

It is crucial at an early stage for the review team to clarify and reassure participants about the priority given to learning over blaming in the systems approach. Organisational backing for this stance also needs to be concretely stated and details about confidentiality clarified.

As a collaborative approach involving a multi-agency group of workers the review team cannot guarantee to keep everything that all individuals tell them confidential. Interim and draft final reports, for example, will draw on the content of individual conversations and need to be shared and discussed with the group. It is important, therefore, that all draft reports

remain confidential to participants in the review team and are not, for example, shared with other staff or managers from the participating agencies.

In final reports, geographic identifiers will be removed, professionals referred to only by their role and the family by pseudonyms.

Individual organisation information gathering

In preparation for multi-agency discussions, each involved organisation will need to prepare a summary of their involvement which may be based on the organisation's:

- Written records
- Conversations with key staff, service users and carers.

Agency leads will be provided with a proforma for completion to ensure all relevant information is available for the Learning Day.

As the Systems Review process requires reflection on what front-line staff (and managers) understood of the situation at the time, what practitioners understood of their role or the part they played in the case and perspectives on what aspects of the whole system were influenced by practitioners, it is important that discussions are held with front-line practitioners which will:

1. Explore their story/narrative
2. Identify turning points or 'key practice episodes'
3. Clarify their 'local rationality'
4. Discuss contributory factors
5. Highlight things that went well
6. Explore their ideas about useful changes

Reviewers need continually to be comparing the data from these different sources, so that each helps to make sense of the other – critically appraising documentation in light of participants' narratives as well as further questioning staff about their narratives in light of information the documentary sources reveal.

Records provide the formal account of professional involvement. In a SAR, access to these documents is legally permitted. In other contexts, access may be restricted, with a consequent limiting effect on the analysis of practice. These written documents provide essential details but are necessarily and intentionally selective and, therefore, incomplete.

Documentation provides a vital check on the accuracy of the basic factual details of the case. Individual accounts are likely to be influenced both by lapses in memory and in being remembered through the filter of knowing what happened later in the case. Separate agency sources also provide a check on accuracy of any one, thus identifying gaps or mistakes in understanding that need to be clarified.

Documentation can give significant insights into the cultures of communication both within and between sectors. It can highlight what is included and what becomes written out of the

formal record, and to what effect. It can give an indication of how tools are actively shaping practice through the ease or difficulty review team members have in making sense of the information contained (c.f. White et al, 2008, p 12).

Multi-agency Review meetings/Group discussions (Learning Day)

Principles

The purpose of a Group discussion "learning day" is to draw together and make sense of professional involvement, and complete multi-agency conversations.

It is anticipated that there will be two group learning days:

1. Initial learning day to gather together the learning from individual organisations
2. A review day to explore/challenge the first draft report and clarify any unclear areas.

Example Outline agendas for the two days

Example agenda which will be dependent on case are:

1. Introductions a. To each other b. To the day and process c. Conventions and ground rules 2. Each agency author to give a brief summary of their agency involvement and the key learning points (max.10 minutes) 3. Discussion focusing on: a. Clarifications b. Systems and Structures c. Policies and Procedures d. Inter-agency Processes 4. Emerging Themes (highlighted on OHP or flipchart) a. Any further clarifications required b. Family's views c. Planning the recall day d. Feedback on the process and the Learning Day	1. Draft report review 2. Discussion / changes required 3. Next steps 4. Dissemination of Learning

Report

The lead reviewers, with the support of the review panel, will prepare a report based on the issues identified within the organisational reflections and arising from the learning day.

The report will incorporate a narrative of agency involvement in the case.

The narrative will identify key practice episodes which participants and the reviewers believe to be significant.

Analysis of the information available will take place whilst noting that:

- There is no absolute truth about a case and putting together the various accounts requires interpretation by the review team.
- Participants provide a vital check on basic accuracy of the facts.

- Participants also need to validate the prioritisation of issues by the reviewers.
- As a result draft(s) of the report need to be shared for comment and a further group discussion meeting will need to take place before the report is finalised.

Identification and prioritising generic patterns of systemic factors

The review team needs to be explicit and transparent about the significance of the episodes selected – how each influenced or might have subsequently influenced actions and decisions and the way the case was handled. Ultimately a judgement needs to be made on how a particular episode was linked to outcomes. the review team need to comment on the adequacy of the judgements and decisions that make up each particular episode. It is helpful, for example, to consider what information was or should have been used to inform the process. The review team needs to consider how the using, or ignoring, of available information actually influenced, or potentially might have influenced, subsequent episodes. We found that each key practice episode tended to include both good and problematic elements of practice. As opposed to a one-off judgement, therefore, it proved more useful to break the episode down into smaller constituent parts and make judgements of each part explicit.

The final aspect involves identifying contributory factors from across the various participants' accounts.

Making recommendations

In System Reviews – there needs to be an acknowledgement that not all findings can be transferred into SMARTER recommendations.

SCIE identify the possibility of 3 different kinds of recommendations which can be usefully distinguished:

1. Issues with clear cut solutions that can be addressed locally and by all relevant agencies.
2. Issues where solutions cannot be so precise because competing priorities and inevitable resource constraints mean there are no easy answers.
3. Issues that require further research and development in order to find solutions, including those that would need to be addressed at a national level.

The review team will need to be clear about those issues which can be addressed, and those which may need to be highlighted to the SAB or into national systems.

Accountability and Responsibility

'The Substitution Test'

When undertaking a systems review individuals behaviour is located in the setting and the sense people made at the time. By doing this the review will consider whether the information made available and the subsequent decisions made sense to others. As soon as you believe that any other practitioner would have done the same thing as the one whose assessments and actions are now controversial, the substitution test will be applied. If you

substitute one practitioner for another and imagine the same thing would have happened, the system needs considering not the individual.

The ethos around undertaking a systems review is to involve frontline practitioners and understand their experience and subsequent action and decisions. As such, practitioners will have the opportunity to tell their story. Where the substitution test cannot be applied and there are concerns regarding the staff members code of conduct, these are expected to be dealt with through individual agencies human resources procedures.

Learning lessons locally

As the purpose of SAR's is to learn lessons for improving both individual agency and multi-agency working it is essential that the lessons learnt are acted upon. This means that as much effort should be spent on implementing recommendations as on conducting the review. Consideration will be given to the following:

- As far as possible conducting the review in such a way that the process is a learning exercise in itself for all those who have been involved in the case.
- What type and level of information needs to be disseminated, how and to whom.
- Communication of good practice and areas where change is required, as well as how to integrate this information with that from other serious case or local reviews requires preparation and consideration.
- Delivering specific briefing sessions to senior managers and relevant staff members following the publication of a review.
- Incorporating the learning from the review into relevant SAB training.
- Sharing the learning from the review through the SAB newsletter and practice updates.
- Assessing how the learning from the review has been implemented through the routine case audit process the SAB has in place.
- Making recommendations on a small number of key areas with SMARTER proposals for change and intended outcomes.
- The monitoring and auditing processes of all agencies against recommendations and intended outcomes.

2) Traditional Safeguarding Adults Review approach using Individual Management Review Reports

Where the methodology utilised involves the completion of reports by individual agencies/services, the involved organisations will be identified. The SAB Chair will write to the SAB Board member for the organisation, with the Terms of Reference for the review. The organisation will be required to appoint an IMR Author, and the senior officer will be required to confirm in writing the name of the person who will be completing the IMR. The senior officer must make arrangements within their agency for the timely completion of the IMR. The IMR will need to be returned to the SAB Manager by the deadline identified in the terms of reference and following approval and signature by the agency senior officer.

The IMR author

- The IMR author must have sufficient seniority and no significant involvement or line management responsibility for services delivered in the case under review.
- The IMR Author should have a thorough understanding of safeguarding practice and procedures.
- As preparation for commencing the IMR, a meeting will be held with all relevant agency authors to go through the terms of reference, requirements and timescale for the SAR.
- The undertaking of an IMR is a significant piece of work for authors and agencies should ensure that IMR authors are released from existing commitments to be able to prioritise this piece of work and also arrange for them to have appropriate administrative support.

The IMR

The aim of IMR's should be to look openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and if so, to identify how these changes can be brought about.

The IMR reports should be quality assured by the senior officer in the organisation which has commissioned the report, and when they are satisfied, then the findings accepted. The senior officer will also be responsible for ensuring that the recommendations of the IMR and, where appropriate, the overview report are acted upon.

Individual Management Reviews will be completed using a standardised and consistent format set by the Lead Reviewer and SAB SAR Group. The individual agency chronology must be completed using the format issued by the SAB, this format must not be deviated from; the key areas which are likely to form the chronology and the IMR format can be found at Appendix 3.

Where staff or others are interviewed by those preparing IMR's a written record of such interviews should be made and this should be shared with the relevant interviewee. If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed in order to understand the reason for this.

On completion of each IMR report there should be a process of feedback and debriefing for the staff involved in the case in advance of completion of the overview report. There should also be a follow up session with those staff once the SAR report has been completed and before the report is published. It is important that the SAR process supports an open, transparent, just and learning culture and is not perceived as a disciplinary type hearing which may intimidate and undermine the confidence of staff.

As part of completing the IMR, authors will have unrestricted rights of enquiry and access to staff, records and files. It is envisaged that the IMR Authors will wish to interview staff who are central to the case. Staff who wish to be interviewed should be offered this opportunity.

IMR reports must be signed off by the SAB member for the agency prior to their submission to the SAB Manager.

3) Root Cause Analysis

This model aims to uncover a number of causes of an event or factors which contributed to an event. It systematically looks beyond the individuals concerns and seeks to understand the underlying causes and environmental context in which the incident happened.

Understanding why an incident occurred is a fundamental part of this review process and this is uncovered by dissecting what may be a complex chain of events and the interaction between local conditions, human behaviour, social factors and organisational issues.

This model is familiar to health care settings and there can be different scales of an RCA depending on the scale of the incident.

4) Significant Event analysis

This option brings together managers and/ or practitioners to consider significant events within a case and analyse together what went well and what could have been done differently.

This method has been used for many years in the NHS and historically it was used in General Practice however it is relevant to use this method in other areas of professional practice. The analysis of a significant event can be guided by answering four questions:

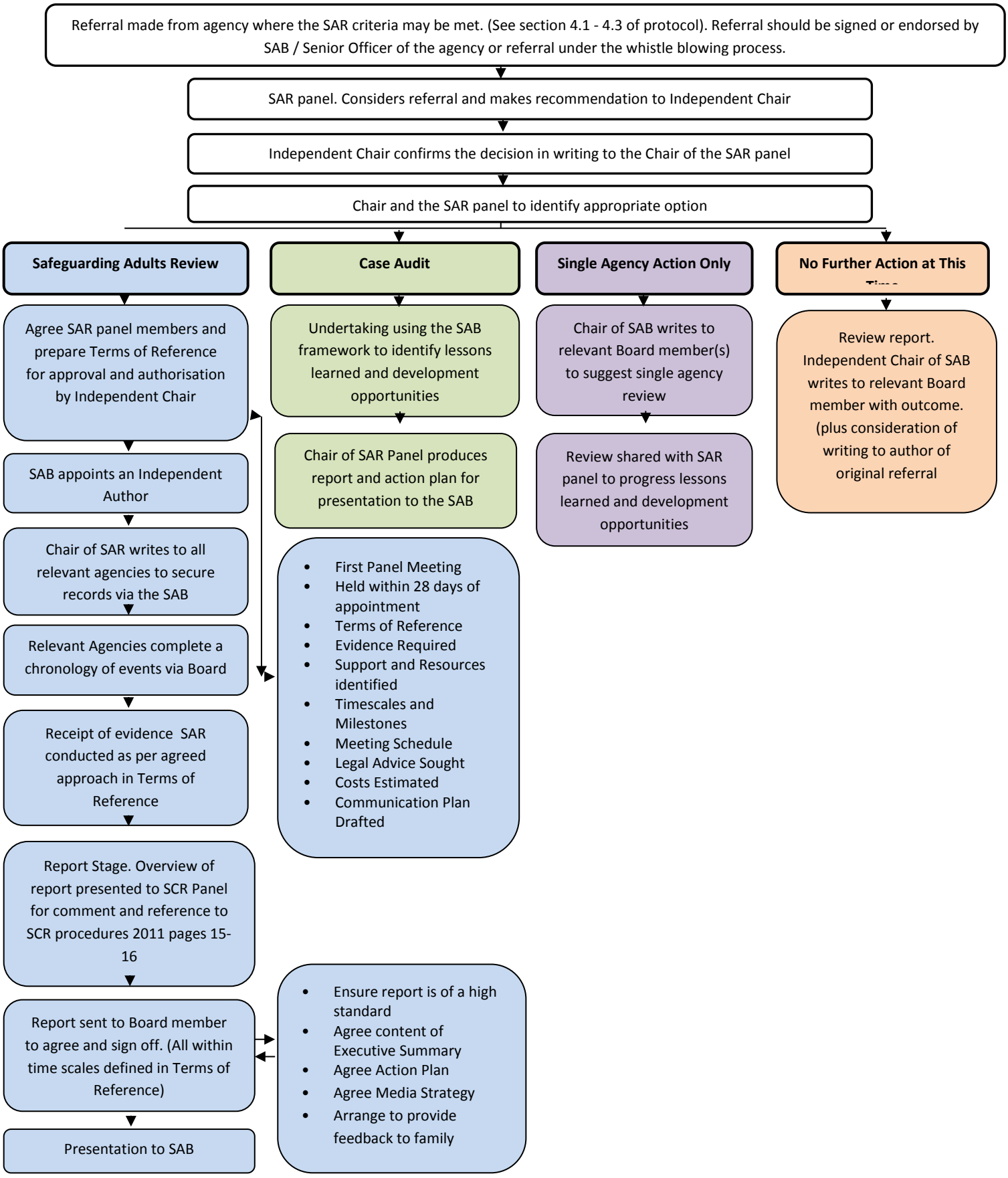
- What happened?
- Why did it happen?
- What has been learned?
- What has been changed or auctioned?

10. Funding of the Safeguarding Adult Review

The anticipated cost of undertaking a SAR is difficult to quantify however by taking the learning from LSCB's a review can cost between £20,000 to £100,000. An initial outlay of £20,000 has been identified as an amount to fund a SAR should the Board need to undertake one.

The funding of the learning and development framework will be split 20% each for the statutory agencies police, council and health. The remaining 40% will be split equally amongst other Board members.

Appendix 1 Flowchart demonstrating 4 outcomes of a referral for Safeguarding Adults Review



Further considerations for a Safeguarding Adult Review

There will be a requirement to address the budgetary arrangements for undertaking a Safeguarding Review.

Time scales for the completion of a Safeguarding Review will require agreement. A Domestic Violence Homicide Review aims to be completed within three months.

- The Board will liaise with the local Coroner's Office to ensure that the arrangements for undertaking a Safeguarding Review are acceptable.
- Due regard for criminal and civil process should be observed at all times.
- Arrangements to obtain or secure records through statutory agencies should be utilised whenever appropriate, e.g. Police, Care Quality Commission.
- Circumstances may arise whereby it is appropriate to consult or involve a victim of abuse or a relative. This involvement should be carefully considered
- The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the 'right to know', came into force in January 2005
- There are 'absolute' and 'qualified' exemptions under the Act. Where information falls under 'absolute exemption', the harm to the public interest that would result from its disclosure is already established
- If a public authority believes that the information is covered by a 'qualified exemption' or 'exception' it must apply the 'public interest test'
- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it
- The Data Protection Act 1998
- Children Act 1989 – updated 2004
- There may be need for the completion and implementation of media and communication strategies

APPENDIX 2 Safeguarding Adult Review Referral Form

Referrer's details	
Name	
Agency	Role
Contact details Work Tel - Mobile - Email –	Address
Name and contact details of Designated Safeguarding Manager this referral has been discussed with:	
Subject Person(s) Details	Gender and ethnicity
Name	Date of Birth
Date of incident	
Current Address	Previous addresses
Family and significant others (inc Date of Birth and address)	Relationship to subject
Known Service Provision (subject and family/carers) – please note this includes • local and out of authority services, • Children's Services, • Adult Social Care, • Police, • GP(Specify the GP's name and address), Housing, • Education, • Community Health Services Acute Health Service, • Mental Health Service Drug/Alcohol Services, • Probation,	

• Voluntary (please specify the services)	
Please outline the circumstances of the incident (death, serious injury, referral to protective services). Include in this section detail of any internal review or single agency investigation being undertaken as a result of the incident. Please outline the reason for the referral.	
Please outline a brief chronological explanation of your agency's involvement with the subject, parents/carers and significant others.	

Appendix 3 Safeguarding Adult Review Recommendation Proforma

Recommendation Proforma	
Date of the Panel:	
Members of the Panel: In attendance:	
Name of the adult(s) Date of birth Referral received from: Date referral received: Date referral considered by the SAR Group: Date the Chair of the SAB informed:	
A SAR must be undertaken where an adult has died in its areas as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The SAB must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect, where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life as a result of abuse or neglect. SAB's are free to arrange for a SAR in any other situations involving an adult in its area with care and support needs.	
Does the case meet the requirement stated above?	Yes/No, Reasons why
Details of the case	

Recommendations and reasoning to include type of review being recommended	
Are all group members in agreement?	Yes/No
Are all group members in agreement, if not detail who and why not	Yes/No, Reasons why
Signature of Safeguarding Adults Review Group chair:	
Date:	
Recommendations to the Independent Chair:	
Independent Chair response:	
Independent Chair decision:	
Signature of Independent Chair:	