



## **Part 2**

# **MULTI-AGENCY POLICY AND PROCEDURES FOR SAFEGUARDING VULNERABLE ADULTS**

## **Appendices**

Valid from January 2011 to January 2012

# APPENDICES

These appendices include additional guidance that may be relevant to particular agencies or roles within the safeguarding process.

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## APPENDIX 1: GLOSSARY OF TERMS

|                                 |   |
|---------------------------------|---|
| <b>Abuse</b>                    | Abuse is a violation of an individual's human and civil rights by any other person or persons.  |
| <b>Alert</b>                    | Reporting of concerns of actual or suspected abuse or neglect to the appropriate helpdesk, Assessment or Duty team. Any immediate protection needs are identified and addressed.  |
| <b>BCC Safeguarding Team</b>    | Central safeguarding team employed by BCC to give advice and guidance to partners and to undertake complex investigations.  |
| <b>Case Conference</b>          | A multi-agency meeting involving the service user to agree a protection plan.   |
| <b>Disclosure</b>               | A disclosure is when a vulnerable adult tells another person of abuse that has happened to them. If someone discloses abuse it is important to respond in the correct way   |
| <b>Discriminatory Abuse</b>     | Is the harassment, unfair treatment, exploitation or denial of mainstream opportunities and services to individuals because of their race, religion, culture, gender, age, sexuality or disability. Discrimination can be a motivating factor in other forms of abuse   |
| <b>Financial/Material Abuse</b> | Is the unauthorized and improper use of funds, property or any resources belonging to an individual. Unauthorized would include the coercion or misleading of an individual, or any lack of informed consent from the individual.   |
| <b>Harm</b>                     | Should be taken to include not only ill-treatment (including sexual abuse and forms of ill-treatment that are not physical); but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, emotional, social or behavioral development   |
| <b>Institutional Abuse</b>      | Can take the form of any of those described above, but is caused by an unsatisfactory regime of health, care or support provision. It occurs when routines, systems and norms of an institution override the needs of those it is there to support. It is the existence of isolated or collective examples of poor and unsatisfactory professional practice, misconduct or pervasive ill-treatment. |

|                                      |   |
|--------------------------------------|---|
| <b>Investigation</b>                 | Coordinating the collection of the information/evidence about the abuse or neglect that has or might occur. This may also include other investigative processes, e.g. a criminal or disciplinary investigation.   |
| <b>Investigating Manager</b>         | The manager responsible for coordinating the safeguarding adult's responsibilities within a team.   |
| <b>Investigating Officer</b>         | Any individual staff member identified by the Investigating Manager to take the practice lead for an investigation.   |
| <b>Investigation Team</b>            | The AFW Department has lead responsibility for coordinating adult protection investigations and all referrals must be reported to the appropriate AFW team, (This may be a multiagency team such as a Community Mental Health Team.) Note: in West Buckinghamshire, Health Service in-patient units have the option to take lead responsibility for investigating alerts. |
| <b>Level of Response</b>             | Determining the most appropriate and proportionate response to the Adult Protection referral using one of the four levels of investigation.   |
| <b>Neglect or acts of omission</b>   | Neglect or acts of omission is the repeated deprivation of assistance that the vulnerable adult needs for important activities of daily living, including a failure to intervene in behaviour which is dangerous to the vulnerable adult or others  |
| <b>Physical Abuse</b>                | Is the non-accidental physical mistreatment of one person by another which may or may not result in physical injury. It can be the use of force that results in an unwanted change in a person's physical state.  |
| <b>Protection plan</b>               | Coordinating a multi-agency response to the abuse that has been identified in order to reduce or eradicate the risk of further abuse taking place.  |
| <b>Psychological/Emotional Abuse</b> | Is the use of threats, humiliation, bullying, other verbal conduct or any other form of mental cruelty that results in mental or physical distress.<br><br>Emotional abuse is any act which negatively affects the emotional well being of a person or impairs their psychological development.   |
| <b>Recording and monitoring</b>      | Recording and monitoring the adult protection investigation and its outcomes.   |

|   |  |
|---|--|
| <b>Referral</b>                                 | When an alert is sent to BCC, and BCC accept this as a Safeguarding concern then this is a referral.   |
| <b>Review Case Conference</b>                   | The review of the Adult Protection plan.   |
| <b>Screening Decision</b>                       | Deciding whether these multi-agency procedures are appropriate to address the concern detailed in the alert.   |
| <b>Sexual abuse</b>                             | Is the direct or indirect involvement in any sexual activity to which a person does not give valid consent or cannot give valid consent. A person cannot give valid consent when they lack capacity to make a decision or if they are coerced into activity because the other person is in a position of authority, trust or power   |
| <b>Strategy meetings and discussions</b>        | Formulating a multi-agency plan for assessing risk and undertaking the investigation into the adult protection concerns.   |
| <b>Threshold decision</b>                       | <ul style="list-style-type: none"> <li>• Decision by a manager as to ;</li> <li>• Whether referral should be dealt with under Safeguarding Adults procedures</li> <li>• What Immediate action is required to keep person safe is identified and initiated</li> <li>• Whether Referrals are required to other agencies e.g. police</li> <li>• Whether Additional information is required- do we have basic information <i>who, what, where, when</i></li> <li>• Determine who should lead on the investigation</li> </ul> |
| <b>Vulnerable person could be a person with</b> | <ul style="list-style-type: none"> <li>• A mental health problem (including dementia)</li> <li>• A physical disability</li> <li>• Drug and alcohol related problems</li> <li>• A sensory impairment</li> <li>• A learning disability</li> <li>• A physical illness</li> <li>• An acquired brain injury</li> <li>• Frailty and/or a temporary illness</li> </ul>  |

## APPENDIX 2: THRESHOLDS OF INTERVENTION

### *The use of thresholds to support decision making*

The use of thresholds enables the effective allocation of resources and skills. They serve to distinguish abusive acts that require external safeguarding procedures and acts that constitute poor practice and should be subject to service provider interventions. This guidance is designed to support decision-making regarding whether an incident, once referred into safeguarding procedures qualifies for an Option 1 response (service provider intervention) or indicates a need for higher levels of response Option 2, 3 or 4.

In using threshold criteria, professional judgment is required. This can be complex, particularly in concerns such as neglect, where actions can fall in a continuum from poor practice to significantly harmful events. The use of thresholds however should facilitate consistent decision making, both within and between agencies, in order to ensure that the most effective response is made to any alert raised and that safeguarding procedures are used to maximum effect.

### *Incidents falling below the threshold:*

An incident falling below threshold does not mean it is not serious or can be ignored. Instead, it determines that the most effective intervention will be through an internal investigation by the provider organisation itself. Providers must accept the importance of responding to such incidents in a robust and immediate way, focusing on improving the life of the vulnerable adults in their care. Failure to act effectively on below-threshold incidents will lead to more serious abuse occurring in the future.

Openness and responsiveness to complaints, poor professional practice and abuse is central to abuse prevention. Service providers must ensure that systems are in place which identify **all** incidents of concern and enable robust and timely responses, whether above or below threshold. A good and proactive provider organisation will enable this identification and response and monitor the effectiveness of their reactions, as well as ensuring that all incidents are actively referred into safeguarding procedures for assessment and decision about the most appropriate response.

### *General threshold guidance:*

- In all situations where a criminal offence may have occurred, a referral to Safeguarding Adults procedures and the police must be made immediately.
- In all situations where there is doubt or insufficient information to decide on the threshold, a referral should be made to Safeguarding Adults procedures.
- If, in the process of investigating or responding to an incident below the threshold, findings suggest the threshold is breached, or a criminal offence has occurred, a referral must be made to safeguarding adults procedures.

The framework for these thresholds is taken from: Collins, M (2010) *“thresholds in adult protection”* *Journal of Adult Protection* 12:1 (Hove: Pier Professional). Some adaptations have been made for the purposes of this guidance.

| <b>THRESHOLDS FOR SAFEGUARDING ADULTS PROCEDURES</b> |   |  |
|--|---|--|
|  | <b>Poor practice that requires robust and immediate action by the provider organisation: e.g. hospital, care home, housing or other support service</b>   | <b>Possible abuse that requires reporting as such and the instigation of safeguarding adults procedures</b>  |
| <b>1</b>   | <p>Vulnerable adult does not have within their plan of care(*) a section that addresses a significant assessed need, but no harm occurs</p> <p><i>Assessed needs may include:</i></p> <ul style="list-style-type: none"> <li>• Management of behaviour to protect self or others</li> <li>• Liquid diet due to swallowing difficulty</li> <li>• Bedrails to prevent injury</li> </ul> | <p>Failure to specify in vulnerable adult’s plan of care how a significant need must be met. Inappropriate action or inaction relating to this need results in harm such as injury, choking etc.</p>             |
| <b>2</b>   | <p>Vulnerable adult’s needs are specified in the plan of care, but the plan is not followed and needs are not met. No harm occurs</p>   | <p>Failure to address a need specified in a vulnerable adult’s plan of care results in harm. This is especially serious if it is a recurring event or affects more than one vulnerable adult.</p>                |
| <b>3</b>   | <p>Vulnerable adult does not receive necessary help to have a drink/meal on one occasion</p>  | <p>This is a recurring event or is affecting more than one vulnerable adult.</p> <p>Harm: hunger, thirst, malnutrition, constipation, tissue viability problems.</p>   |
| <b>4</b>   | <p>Vulnerable adult does not receive necessary help to get to the toilet to maintain continence, or have appropriate assistance (such as changed incontinence pads) on one occasion.</p>  | <p>This is a recurring event or is affecting more than one vulnerable adult</p> <p>Harm: loss of continence, reduced continence, pain, constipation, loss of dignity, loss of self-confidence, skin problems</p> |
| <b>5</b>   | <p>Vulnerable adult is known to be susceptible to pressure ulcers and has not been formally assessed with respect to pressure area management but no discernable harm has arisen yet</p>  | <p>Vulnerable adult has not been formally assessed, advice not sought with regard to pressure area management, or plan has not been followed.</p> <p>Harm: avoidable tissue viability problems</p>               |

## THRESHOLDS FOR SAFEGUARDING ADULTS PROCEDURES

|                  | <p><b>Poor practice that requires robust and immediate action by the provider organisation: e.g. hospital, care home, housing or other support service</b></p>  | <p><b>Possible abuse that requires reporting as such and the instigation of safeguarding adults procedures</b></p>  |
|------------------|---|---|
| <p><b>6</b></p>  | <p>Patient does not receive their medication as prescribed on one occasion but no harm occurs</p>   | <p>This is a recurring event or is affecting more than one vulnerable adult</p> <p>Harm: pain not controlled, person kept sleepy/unaware; side affects, put at risk through uncontrolled condition</p>  |
| <p><b>7</b></p>  | <p>Vulnerable adult does not receive recommended assistance to maintain mobility on one occasion</p>  | <p>This is a recurring event or is affecting more than one vulnerable adult</p> <p>Harm: reduced mobility, loss of mobility, confidence and independence</p>  |
| <p><b>8</b></p>  | <p>Appropriate moving and handling procedures are not followed, and/or staff are not trained and competent to use the required equipment, but the vulnerable adult is not harmed</p>  | <p>Vulnerable adult is injured, or failure to adhere to appropriate procedures is common, making this likely to happen</p> <p>Harm: injuries such as falls and fractures, skin damage, lack of dignity</p>  |
| <p><b>9</b></p>  | <p>Vulnerable adult has been formally assessed under the MCA and lacks capacity to recognise danger (e.g. from traffic). Steps taken to protect them are not 'least restrictive'.</p> <p>Steps need to be reviewed and deprivation of liberty referral considered</p> | <p>Restraint or possible deprivation of liberty is occurring (e.g. bedrails, locked doors, medication) and vulnerable adult has not been referred for a DoLS assessment although this is indicated.</p> <p>Person has capacity and is still subjected to unwanted restraint, and/or has not had their rights and freedoms effectively explained and guaranteed.</p> <p>Restraint is occurring without person being assessed in line with the MCA</p> <p>Restraint is occurring, and person's best interests have been ignored or presumed</p> |
| <p><b>10</b></p> | <p>Vulnerable adult is spoken to once in a rude, insulting, belittling or other inappropriate way by a member of staff. Respect for them and their dignity is not maintained but they are not distressed</p>  | <p>This is a recurring event or is affecting more than one vulnerable adult</p> <p>Harm: distress, demoralisation, loss of self esteem and confidence</p>   |

## THRESHOLDS FOR SAFEGUARDING ADULTS PROCEDURES

|    | <b>Poor practice that requires robust and immediate action by the provider organisation: e.g. hospital, care home, housing or other support service</b>  | <b>Possible abuse that requires reporting as such and the instigation of safeguarding adults procedures</b>  |
|----|--|--|
| 11 | Vulnerable adult is discharged from hospital without adequate discharge planning or procedures are not followed, but no harm occurs  | This is a recurring event or is affecting more than one vulnerable adult<br><br>The vulnerable adult is discharged without adequate planning or procedures are not followed, resulting in harm to the vulnerable adult<br><br>Harm: care is not provided resulting in risks, and/or deterioration in health and confidence, avoidable deterioration. |
| 12 | Vulnerable adult does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs.  | This is a recurring event or is affecting more than one vulnerable adult, and/or harm occurs   |
| 13 | One vulnerable adult physically lashes out at another, but has left no mark or bruise and the victim is not intimidated and/or significant harm has not occurred.  | This is a recurring event or is affecting more than one vulnerable adult<br><br>Predictable and preventable (by staff) incident between two vulnerable adults where bruising, abrasions, or other injury have been sustained and/or emotional distress caused.   |
| 14 | Failure to meet an agreed contribution to residential care cost by family member, attorney or statutory agency, but resident still has personal allowance and placement is not at risk<br><br>(this should be treated as failure to meet lawful debt)  | Failure to meet an agreed contribution to residential care cost by family member, attorney or statutory agency results in failure to provide personal allowance and/or jeopardises placement.  |
| 15 | Vulnerable adult has a plan of care that emphasises the importance to them of spiritual or cultural welfare, recommending supported visits to places of worship, cultural events or arrangements for a pastoral visit. Limited efforts are being made to fulfill this agreement but vulnerable adult is philosophical about it | Vulnerable adult is regularly not supported to attend to their spiritual/cultural needs (e.g. attending church, mosque or cultural event) no efforts have been made for them to have pastoral visits.<br><br>Harm: deprivation of an important part of their life, emotional distress, loss of self esteem, confidence.                              |

## THRESHOLDS FOR SAFEGUARDING ADULTS PROCEDURES

|                  | <p><b>Poor practice that requires robust and immediate action by the provider organisation: e.g. hospital, care home, housing or other support service</b></p>   | <p><b>Possible abuse that requires reporting as such and the instigation of safeguarding adults procedures</b></p>  |
|------------------|--|---|
| <p><b>16</b></p> | <p>Vulnerable adult known to mental health services reports that they are contemplating suicide. Previous risk assessment identifies that the risk is low but recommends a same day response. Response is not made that day, but no harm follows.</p>  | <p>Patient is known to be at high risk and no timely response is taken.<br/>Harm: physical injury, emotional and mental distress</p>  |
| <p><b>17</b></p> | <p>Detained patient who has escorted visits has a visit cancelled at short notice with no explanation</p>  | <p>Detained patient has escorted visits repeatedly cancelled (e.g. due to staff shortages).<br/>Harm: distress to patient, loss of confidence and self-esteem, recovery delayed</p>   |
| <p><b>18</b></p> | <p>Vulnerable adult with behaviour that challenges others, whose plan of care stipulates that they should be accompanied by two staff, is taken by one member of staff to avoid disappointment of vulnerable adult. No harm occurs.</p>  | <p>Vulnerable adult is regularly taken out by only one member of staff, thereby putting them or others regularly at risk<br/>Harm: may harm self or others.</p>   |
| <p><b>19</b></p> | <p>Vulnerable adult attends casualty, minor injury unit or GP surgery with a minor injury and doubtful explanation and/or lack of capacity to provide explanation, wants treatment but no other action. Doctor/professional fails to check if there have been previous such incidents, but none have been recorded</p> | <p>Vulnerable adult has injuries and dubious explanation and/or lack of capacity to provide explanation. Doctor/professional fails to check for previous incidents, or does check, identifies others and then fails to refer.<br/>Vulnerable adult has injuries and dubious explanation and possibly lacks capacity to make decision regarding referral<br/>Harm: potential physical abuse or neglect continues</p> |
| <p><b>20</b></p> | <p>Vulnerable adult is in pain, or otherwise in need of health care (such as dental, optical, audiology assessment, foot care or therapy) and on one occasion does not receive required/requested medical attention in a timely fashion</p>  | <p>This is a recurring event or is affecting more than one vulnerable adult<br/>Vulnerable adult is provided with an evidently inferior medical service or no service and this is likely to be because of their age or disability<br/>Harm: pain, distress and deterioration in health</p>  |

## THRESHOLDS FOR SAFEGUARDING ADULTS PROCEDURES

|           | <b>Poor practice that requires robust and immediate action by the provider organisation: e.g. hospital, care home, housing or other support service</b>  | <b>Possible abuse that requires reporting as such and the instigation of safeguarding adults procedures</b>  |
|-----------|--|--|
| <b>21</b> | Vulnerable adult is known to be living in housing that places them at risk from predatory and or significant anti-social behaviour from neighbours or others in the community and housing department/ association is slow to respond to an application for urgent re-housing, but no harm occurs | Housing provider fails to respond to the urgent need within their own timescales<br><br>Harm: financial, physical and emotional abuse, exposure to criminal behaviour  |
| <b>22</b> | Vulnerable adult needs housing repairs arranged by their landlord. There is undue delay but the repairs are completed eventually and no harm occurs  | Landlord persists in not arranging repairs and/or harm occurs due to failure to complete repairs<br><br>Of particular consideration are repairs relating to security, dangerous wiring, heat/damp, or facilities necessary for personal care or food preparation.<br><br>Harm: physical effects to health and safety, emotional distress |
| <b>23</b> | A vulnerable adult resident in a sheltered accommodation/residential or nursing setting reports that they find the manager or staff intrusive and overbearing  | This is a recurring event or is affecting more than one vulnerable adult<br><br>Resident/s report feeling bullied, intimidated and/or frightened and they appear reluctant to explain why.<br><br>Harm: emotional/psychological distress   |

(\*) plan of care refers to the plan used by any organisation to specify the needs and intervention required for a patient, client, or other vulnerable person receiving a service in a particular setting. This will likely be referred to in different ways by different organisations, (e.g. service delivery plan, care plan, support plan, person-centred plan, treatment plan etc.)

## APPENDIX 3: RECORD KEEPING GUIDANCE

Good record keeping is essential for all agencies involved in Safeguarding Adults. It enables appropriate response to concerns and ensures the accountability of individuals and agencies. It is a central part of good professional practice and should be a recognised part of all processes. It is not an optional extra to be completed only when time allows. All records are legal documents and are admissible in civil, criminal and coroners' courts.

### When to Record

- Records should be made at the time of the event or as soon as possible afterwards. Any delay in documenting will lead to errors and omissions for even the most experienced professional.
- If information is remembered after the initial record was written, the "new" information **must not** be slotted into the older entry. Instead it should be a new entry, (dated at the time of writing) but stating the date, time and event to which it refers.
- If any changes are needed, the entry should be crossed out with a single line, and initialed, ensuring that the original entry remains readable. Correction fluid must never be used.

### What to record

All documentation must be clear, concise, factual and accurate.

- Records should be comprehensive enough that a stranger could understand the situation or case without consulting you or anyone else.
- Records should be comprehensive enough that your agency could produce a timeline of events and actions simply by looking at your written records.
- Nothing should be left to assumption: *If it has not been documented, it has not happened.*
- Records should be **factual**. If your own or another's opinion is included it should be clearly indicated. "Professional judgment" will sometimes be needed, but it should not be recorded as a statement of fact, (see Guidance Box 1).
- Professional judgment can only be made within a person's own professional role. For example, professional judgment regarding a pressure ulcer can only be given by a qualified medical practitioner
- Language used should be objective and non-judgmental rather than subjective, (see Guidance Box 2). Remember that an individual can request to see information held about them.

### Events and details to be recorded

- The full name of the person completing any record.
- The facts of the event, (meeting, telephone call, incident etc.): dates, times, names of people present/spoken to.
- If the record relates to a past event or incident, (for example if a client recalls something that happened last week) you should clearly indicate the date/time of the incident as well as the date/time the record is made. If the exact date/time is unknown, records should indicate this.
- All contact (face to face, telephone or email) with the person, carers or alleged abuser; this should include attempted contact.
- All contact with other professional agencies; this should include attempted contact.
- All decisions made, actions taken and the responsibility for carrying out decisions
- When there are differences of opinion, records should be made of the discussion between the persons holding the differing views and the outcome of such discussions.

### *Practice Guidance Box 1*

#### **Fact or Opinion**

- Facts are things **known for certain** to be true that can be supported by evidence. Opinions are judgements and interpretations; things someone **believes** to be true.
- All information recorded must be factual. Where opinions or judgements are recorded it should be clearly indicated whose opinion it is, (who said it or gave the information).

#### **Why is this important?**

- Factual information can provide evidence of a particular event or of our actions. It is a straightforward record of what has been done, seen or heard.
- Opinions and judgements about the same event will vary from person to person. What you interpret as “angry” another person may interpret as “agitated”. This information, unless clearly indicated as opinion, can distort evidence and mislead someone reading a record.

#### **Examples**

**Opinion:** Mr Jones appeared very angry when I tried to talk to him about his son.

**Fact:** When I asked Mr Jones to tell me about his son he raised his voice and said to me “it is none of your business.”

***Can you see how much more helpful the second statement would be if you were reading it?***

- The factual statement provides a clearer representation of what happened.
- There could be lots of reasons why Mr Jones reacted in the way he did. The factual statement allows for those reasons to be considered.
- The first statement loses some of the information at the expense of the recorder’s opinion.

**To tell the difference between fact and opinion means knowing the difference between objective and subjective language**

### *Practice Guidance Box 2*

#### **Objective or Subjective**

- Objective language represents precisely **what someone has seen or heard**. Subjective language is someone’s **interpretation** of what they have seen or heard.
- Documentation should always aim to use objective language. Subjective language should only be used if it is the direct reporting of what someone else has said.

#### **Why is this important?**

- Subjective language can be misleading and it is often affected by our emotions
- Objective language represents the facts, and therefore allows for many different interpretations.

#### **Example**

**Subjective:** When I visited on Tuesday, Mr X appeared drunk

**Objective:** When I visited Mr X on Tuesday, he stumbled three times whilst walking to the kitchen and I had to ask Mr X to repeat what he had said because his words sounded slurred.

**Objective or Subjective**

***Can you see how much more helpful the second statement would be if you were reading it?***

- A stranger reading the second statement would be in a better position to support Mr X.
- There are many different explanations for Mr X's actions, only one of which is that he is drunk. The first statement prevents anyone considering other options.
- Subjective language can be judgemental. By sticking to objective descriptions you can represent a person's behaviour or actions without judging it.
- Whenever you want to use subjective language, think about what you saw or heard that made you think of that word or description. It is this information that needs to be recorded.

## **APPENDIX 4: INFORMATION SHARING PROTOCOL**

### **Introduction**

The intention of this Protocol and the supporting 'Information Sharing Guidance' documentation is to assist professionals from across the full range of services to fulfill their joint responsibility to protect vulnerable adults from abuse. It will provide a common approach to, and understanding of, the responsibilities of all professionals when seeking to share information about vulnerable adults who may be at risk from abuse. All agencies who are partners to BSVAB and responsible under these multi-agency procedures are party to this protocol

### **Purpose of the Protocol**

The purpose of sharing information between the designated agencies is to:

- i. Ensure that relevant information about the alleged abuse of a vulnerable adult is shared between organisations and reported as an alert to the relevant agency
- ii. Enable a detailed investigation to take place
- iii. Enable evidence to be considered in reaching a decision as to whether abuse has taken place
- iv. Enable a multi-agency response to safeguard vulnerable adults from further abuse.

By sharing information, agencies will be able to identify vulnerable adults who are considered to be at risk of abuse. It is anticipated that nominated representatives from the organisations who are parties to this protocol will be engaging in regular multi-agency case discussion in order to secure services for vulnerable adults and their carers.

### **Principles governing the sharing of information under this protocol**

A number of safeguards are necessary to ensure a balance between maintaining confidentiality and sharing information appropriately. The key principles governing the sharing of information are detailed in the Data Protection Act 1998 and the Caldicott Report 1997. The Human Rights Act 1998, the Mental Capacity Act 2005 and the common law 'duty of confidentiality' are also relevant in this context. More specific detail relating to the application of these principles can be found in the 'Information Sharing Guidance' documentation available from HM Government via [www.direct.gov.co.uk](http://www.direct.gov.co.uk)

The parties to this protocol agree to:

- Facilitate the sharing of information wherever such sharing is lawful and need can be demonstrated
- Implement this protocol within their organisation
- Ensure staff adhere to the procedures and arrangements set out in the protocol
- Provide evidence, when requested, that agreed procedures and arrangements have been implemented
- Ensure that all agreements established between partner agencies for the sharing of information are consistent with the protocol

### **Guidance on Information Sharing**

- The aim of this Guidance is to establish a common set of standards to be used by all professionals working with the Multi-Agency Safeguarding Adults Policy. This Guidance should enable practitioners to share information confidently and appropriately. It is not intended to put barriers in the way of information sharing.

- A concern for confidentiality should not be used as a justification for withholding information when it would be in the vulnerable adult's best interest to share it.
- Many agencies already have procedures in place to meet such standards around information sharing and these will continue to be used. The Guidance set out within this document is consistent with Buckinghamshire's overarching protocol for information sharing.
- Anything that applies to an individual and by which they can be identified is personal information. The approach to information sharing with others should be the same whether practitioners are part of the same organisation (e.g. two Social Workers) or not (e.g. a Social Worker and a Police Officer). In practice there is likely to be implied consent for sharing between practitioners in the same organisation, where this is justified.
- This Guidance will help to explain more about such issues as to how, why and when to share information, when consent is needed and when consent is not required.

### **What are the legal restrictions?**

The decision whether to disclose information may arise in various contexts. You may have a concern about someone that might be allayed or confirmed if shared with another agency. In all cases the main restrictions on disclosure of information are: common law duty of confidence; Human Rights Act 1998; and the Data Protection Act 1998.

Each of these has to be considered separately. Other statutory provisions may also be relevant. But in general, the law will **not** prevent you from sharing information with other practitioners if: those likely to be affected consent; or the public interest in safeguarding the person's welfare overrides the need to keep the information confidential; or disclosure is required under a court order or other legal obligation.

#### **A) Common Law Duty of Confidence**

The circumstances in which a common law duty of confidence arises have been built up in case law over time. The duty arises when a person shares information with another in circumstances where it is reasonable to expect that the information will be kept confidential. The courts have found a duty of confidence to exist where: a contract provides for information to be kept confidential; there is a special relationship between parties, such as patient and doctor, solicitor and client, teacher and pupil; an agency or government department, such as Inland Revenue, collects and holds personal information for the purposes of its functions.

The duty is not absolute. Disclosure can be justified if: the information is not confidential in nature; the person to whom the duty is owed has expressly or implicitly authorised the disclosure; there is an overriding public interest in disclosure; disclosure is required by a court order or other legal obligation.

***Is the information confidential?*** Some kinds of information, such as medical records and communications between doctor and patient, are generally recognised as being subject to a duty of confidence. Other information may not be, particularly if it is trivial or readily available from other sources or if the person to whom it relates would not have an interest in keeping it secret.

***Maintaining confidentiality*** As a general rule you should treat all personal information you acquire or hold in the course of working with children and families as confidential and take particular care with sensitive information.

## **B) Consent**

There will be no breach of confidence if the person to whom a duty of confidence is owed consents to the disclosure. Consent can be express (that is orally or in writing) or can be inferred from the circumstances in which the information was given (implied consent).

***Whose consent is required?*** The duty of confidence is owed to the person who has provided information on the understanding it is to be kept confidential and, in the case of medical or other records, the person to whom the information relates.

***Has consent been given?*** You do not need express consent if you have reasonable grounds to believe that the person to whom the duty is owed understands and accepts that the information will be disclosed. For example, a person who refers an allegation of abuse to a social worker would expect that information to be shared on a 'need to know' basis with those responsible for following up the allegation. Anyone who receives information, knowing it is confidential, is also subject to a duty of confidence. Whenever you give or receive information in confidence you should ensure there is a clear understanding as to how it may be used or shared.

***Should I seek consent?*** If you are in doubt as to whether a disclosure is authorised it is best to obtain express consent. But you should not do so if you think this would be contrary to a person's welfare. For example, if the information is needed urgently the delay in obtaining consent may not be justified. Seeking consent may prejudice a police investigation or may increase the risk of harm.

***What if consent is refused?*** You will need to decide whether the circumstances justify the disclosure, taking into account what is being disclosed, for what purposes and to whom.

## **C) Disclosure in the absence of consent**

The law recognises that disclosure of confidential information without consent or a court order may be justified in the public interest to prevent harm to others. The key factor in deciding whether or not to disclose confidential information is proportionality: is the proposed disclosure a proportionate response to the need to protect the individual. The amount of confidential information disclosed, and the number of people to whom it is disclosed, should be no more than is strictly necessary to meet the public interest in protecting health and well-being. The more sensitive the information is, the greater the need must be to justify disclosure and the greater the need to ensure that only those professionals who have to be informed receive the material ('the need to know basis').

### **The 'Need to Know' Basis**

#### **Relevant Factors**

- What is the purpose of the disclosure
- What is the nature and the extent of the information disclosed?
- To whom is the disclosure to be made (and is the recipient under a duty to treat the material as confidential)?
- The proposed disclosure is a proportionate response to the need to protect the welfare of the person to whom the confidential information relates?

**Disclosing information within or between organisations:** The approach to confidential information should be the same whether it is internally within one organisation (e.g. within a hospital, or within social services) or between agencies (e.g. from a doctor to a social worker). The need to disclose confidential information to others within your own organisation will probably arise more frequently than will be the case for inter-agency disclosure.

#### **D) Caldicott Principles: A Guide to Good Practice**

##### *Principle One – Justify the Purpose*

Every proposed use or transfer of personal identifiable information within or from an organisation should be clearly defined and scrutinized, with continuing uses regularly reviewed by an appropriate Guardian.

##### *Principle Two – Don't use personal information unless it is absolutely necessary*

Personal identifiable information items should not be used unless there is no alternative.

##### *Principle Three – Use the minimum necessary personal identifiable information*

Where use of personal identifiable information is considered to be essential, each individual item of information should be justified with the aim of reducing identifiability.

##### *Principle Four – Access should be on a strict need to know basis*

Only those individuals who need access to personal identifiable information should have access to it, and they should only have access to the information items they need to see.

##### *Principle Five – Everyone should be aware of their responsibilities*

Action should be taken to ensure that those handling personal identifiable information are aware of their individual responsibilities and obligations in respect of maintaining client confidentiality.

##### *Principle Six – Understand and comply with the law*

Every use of personal identifiable information must be lawful. A person in each organisation should be responsible for ensuring that the organisation complies with the legal requirements.

#### **E) The Data Protection Act 1998**

The Data Protection Act 1998 regulates the handling of personal data. Essentially, this is information kept about an individual on a computer or on a manual filing system. The Act lays down requirements for the processing of this information, which includes obtaining, recording, storing and disclosing it. If you are making a decision to disclose personal data you must comply with the Act, which includes the eight data protection principles. These should not be an obstacle if:

- You have particular concerns about the welfare of a vulnerable adult;
- You disclose information to social services or to another professional; and
- The disclosure is justified under the common law duty of confidence.

## **F) The Mental Capacity Act 2005**

Chapter 16 of the Mental Capacity Act Code of Practice offers guidance on: what personal information about someone who lacks capacity people involved in their care have the right to see, and how they can get hold of that information.

*Questions to ask when requesting or disclosing personal information about someone who may lack capacity:*

- Am I acting under a Lasting Power of Attorney or as a deputy with specific authority?
- Does the person have capacity to agree that information can be disclosed? Have they previously agreed to disclose the information?
- What information do I need?
- Why do I need it?
- Who has the information?
- Is the disclosure justified under the principles of the MCA: (the person lacks capacity, it is in their best interests and it is the least restrictive of their right to privacy)
- Do I need to share the information with anyone else to make a decision that is in the best interests of the person who lacks capacity?
- Should I keep a record of my decision or action?
- How long should I keep the information for?
- Do I have the right to request the information under section 7 of the Data Protection Act 1998?

A person may have the capacity to agree to someone seeing their personal information, even if they do not have the capacity to make other decisions. In some situations, a person may have previously given consent (while they still had capacity) for someone to see their personal information in the future.

## **G) Other Statutory Provisions**

Section 115 of the Crime and Disorder Act 1998 enables any person to disclose information to a relevant authority for any purposes of the Act if they would not otherwise have the power to do so. Relevant authorities include local authorities, NHS bodies and police authorities. The purposes of the Act broadly cover the prevention and reduction of crime and the identification or apprehension of offenders.

### **PRACTICE GUIDANCE**

The following are questions to ask yourself when asking for or disclosing personal information

#### **Why do I/they want this information?**

- The purpose of the information sharing should be explicit
- The information sharing may be justified if the purpose of the sharing is clearly in the best interests of the vulnerable adult

## **PRACTICE GUIDANCE** *continued*

### **Can I/they demonstrate sufficient need to know?**

- The actions taken or services given should be different after the information is known
- The information is necessary for the performance of a job or a statutory function

### **Is the request proportionate to the purpose for which the disclosure is sought?**

- The information shared must be the minimum necessary to achieve the aim

### **Is the information up to date and accurate?**

- Many difficulties with information sharing arise because the information is not accurate or because an opinion is given as fact

### **Will the request involve secondary disclosure?**

- Information belongs to the person or agency that supplies it
- Information should not be passed to a third party without consent
- Information gathered for one purpose cannot be used or passed on for a different purpose

### **Do I need consent?**

- In most cases there is a legal requirement to obtain consent before any personal information can be shared
- Consent can be implied
- Failure to gain consent may make the individual practitioner and the agency liable to prosecution
- The vulnerable adult must understand what they are agreeing to and the practitioner must record that consent has been given

### **Have I got consent?**

- Consent should not be assumed
- Practitioners must check whether the vulnerable adult still gives consent, particularly if circumstances change
- Practitioners must know what to do if consent is refused

### **If I cannot get consent is there another justification for disclosure?**

- Sharing information without consent may be necessary and appropriate under some circumstances such as:
  - When a vulnerable adult is believed to be at serious risk of harm
  - When there is evidence of serious public harm or risk of harm to others
  - Where there is evidence of serious health risk to an individual
  - For the prevention, detection or prosecution of serious crime
  - When instructed to do so by a Court

### **Have I recorded that I have shared this information?**

- Practitioners should keep a dated record of what information has been shared and with whom it has been shared

### **Am I sharing this information in a secure way?**

- Secure means that all reasonable steps have been taken to prevent the information being passed to someone that does not have the right to it

**Sample form:**

|  |
|--|
| <b>INFORMATION SHARING IN RESPECT OF SAFEGUARDING ADULTS<br/>INVESTIGATION</b> |
|--|

**AGREEMENT TO THE SHARING OF PERSONAL INFORMATION**

The purpose of this Form is to allow you to give consent to the professional working with you to share some or all of the information held about yourself or your family situation in order to complete a Safeguarding Adults investigation.

All organisations providing services to adults store and record information. They also need to communicate with other professionals in other organisations who may be involved with an adult or hold information about him/her.

The professional working with you will give you a general leaflet explaining what information is held about you, why it is held, why it is shared with other agencies as well as providing details about the law and your rights.

|                                       |  |
|---------------------------------------|--|
| <b>Name of Agency seeking consent</b> |  |
|---------------------------------------|--|

|  |
|--|
| Purpose and extent of proposed information sharing including, where possible, those agencies information is to be shared with: |
|--|

Please tick one of the following:

|  |                          |
|--|--------------------------|
| I agree that my personal information may be shared with appropriate staff of other organisations as named above  | <input type="checkbox"/> |
| I do not agree that my personal information may be shared  | <input type="checkbox"/> |
| I agree that my personal information may be shared with appropriate staff of other organisations as named above with the exception of those named below: | <input type="checkbox"/> |

I consent to the sharing of my personal information and understand that, from time to time, my consent to share this information will be reviewed. I also understand that information is held about me and I have had the opportunity to discuss the implications of this.

Signed: \_\_\_\_\_ (Vulnerable adult) Date: \_\_\_\_\_  
(if appropriate)

Print name: \_\_\_\_\_

Signed: \_\_\_\_\_ (Carer) Date: \_\_\_\_\_  
(if appropriate)

Print name: \_\_\_\_\_

Signed: \_\_\_\_\_ (Staff Member) Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Job Title \_\_\_\_\_

Organisation \_\_\_\_\_

**Copies of this form should be:**

1. Given to the Service User and/or Carer
2. Placed on individual file

**APPENDIX 5: BUCKINGHAMSHIRE HOSPITAL TRUST GUIDANCE**  
**(*Untoward Incidents and Safeguarding*)**

Matt Dooley BHT

For Buckinghamshire Hospital Trust staff specific guidance can be found by clicking on to the intranet site and searching for

“Organisation–wide management of Incidents, including SUIs”

<http://bhtnet/lib/45666/13871/Incident%20Reporting%20Policy%20V4.1%202009.pdf>

or contact Matt Dooley Operations Manager Specialist Medicines.

## APPENDIX 6: ALERT FORM

### 1. Details of Vulnerable Adult

|   |                   |                |   |                                      |
|---|-------------------|----------------|---|--------------------------------------|
| <b>TITLE</b>  | <b>FIRST NAME</b> | <b>SURNAME</b> | <b>SWIFT NO.</b><br>(if known)                                    | <b>DATE OF BIRTH</b><br>(approx age) |
| <b>ADDRESS</b>  |                   |                | <b>TYPE OF ACCOMODATION</b>                                       |                                      |
| <b>POSTCODE</b><br><b>TELEPHONE NO.</b>   |                   |                | <b>ACCESS</b>   |                                      |
| <b>LANGUAGE(S)</b>  |                   |                | <b>INTERPRETER NEEDED?</b>  |                                      |
| <b>MARITAL STATUS</b>   |                   |                | <b>GENDER</b> Female/Male   |                                      |
| <b>ETHNIC ORIGIN</b> (please tick)  |                   |                |   |                                      |
| Asian/Asian/British Bangladeshi <input type="checkbox"/>  |                   |                | Asian/Asian/British Indian <input type="checkbox"/>               |                                      |
| Asian/Asian/British Other <input type="checkbox"/>  |                   |                | Asian/Asian/British Pakistani <input type="checkbox"/>            |                                      |
| Black/Black/British African <input type="checkbox"/>  |                   |                | Black/Black/British Caribbean <input type="checkbox"/>            |                                      |
| Black/Black/British Other <input type="checkbox"/>  |                   |                | Chinese <input type="checkbox"/>                                  |                                      |
| Mixed Other <input type="checkbox"/>  |                   |                | Mixed White and Asian <input type="checkbox"/>                    |                                      |
| Mixed White and Black African <input type="checkbox"/>  |                   |                | Mixed White and Black Caribbean <input type="checkbox"/>          |                                      |
| Other Ethnic Group <input type="checkbox"/>   |                   |                | White British <input type="checkbox"/>                            |                                      |
| White Irish <input type="checkbox"/>  |                   |                | White Other <input type="checkbox"/>                              |                                      |
| Other (please specify) <input type="checkbox"/>   |                   |                |   |                                      |
| <b>RELIGION</b>   |                   |                | <b>DOES THE VULNERABLE ADULT KNOW ABOUT THIS REFERRAL?</b> Yes/No |                                      |
| <b>SERVICE USER GROUP</b> (please tick)   |                   |                |   |                                      |
| Learning Disability <input type="checkbox"/>  |                   |                | Physical Disability <input type="checkbox"/>                      |                                      |
| Mental Health <input type="checkbox"/>  |                   |                | Sensory Impairment <input type="checkbox"/>                       |                                      |
| Older Person <input type="checkbox"/>   |                   |                | OPMH <input type="checkbox"/>                                     |                                      |
| Homeless <input type="checkbox"/>   |                   |                | Substance Misuse <input type="checkbox"/>                         |                                      |
| Other (please specify) <input type="checkbox"/>   |                   |                |   |                                      |
| <b>G.P</b>  |                   |                | <b>NEXT OF KIN</b>  |                                      |
| <b>TELEPHONE NO.</b>  |                   |                | <b>RELATIONSHIP</b><br><b>TELEPHONE NO.</b>                       |                                      |
| <b>IF PERSON HAS A CURRENT CARE PACKAGE, IS IT:</b>   |                   |                |   |                                      |
| <b>COMMISSIONED BY BCC?</b> Yes/No      If yes, which team?   |                   |                |   |                                      |
| SELF FUNDED <input type="checkbox"/> SELF DIRECTED SUPPORT <input type="checkbox"/> DIRECT PAYMENT <input type="checkbox"/> |                   |                |   |                                      |

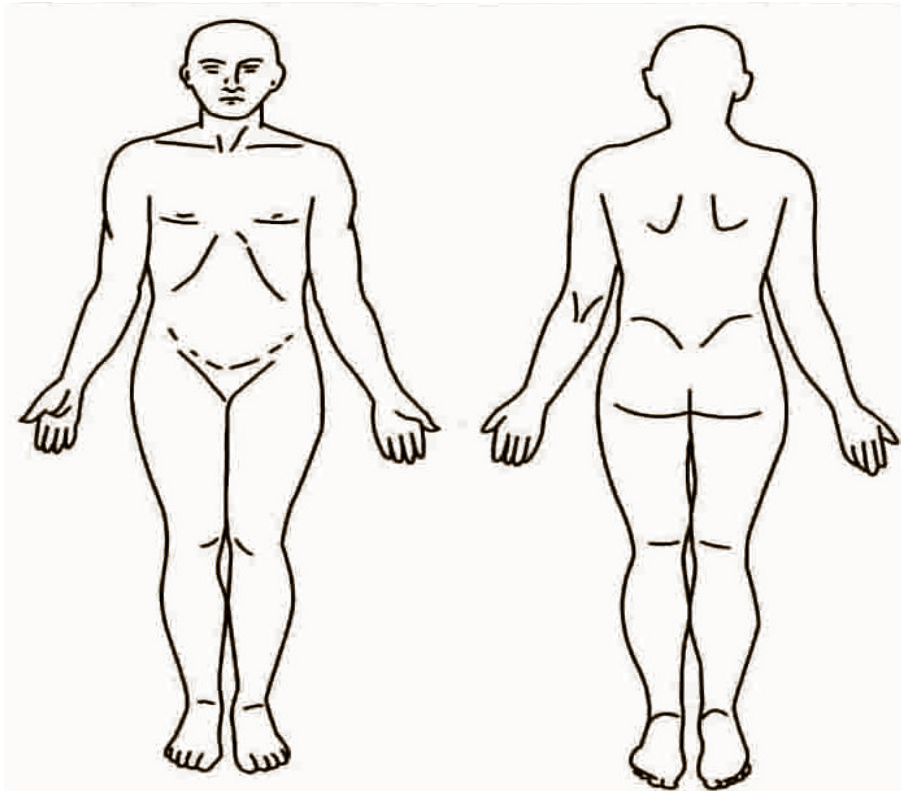
## 2. Details of Concern

### BRIEF FACTUAL DESCRIPTION OF INCIDENT

(please circle)

Suspected / Alleged / Actual / Disclosed

**Body maps: please indicate position on body of marks or injuries, note colour of any injury, whether skin is broken or anything else of relevance.**



**Keep your answers factual, tell us what you heard/saw, and what you said and did. Use injury charts above/**

**What explanation for the injuries/marks was given, and by whom?**

**DATE OF INCIDENT**

**TIME OF INCIDENT (if known)**

### 3. Type of Abuse

|   |   |
|---|---|
| <b>PLEASE TICK ALL THAT MAY APPLY</b><br>(please tick)  |   |
| Physical <input type="checkbox"/><br>Neglect/Acts of Omission <input type="checkbox"/><br>Institutional <input type="checkbox"/><br>Rights <input type="checkbox"/> | Sexual <input type="checkbox"/><br>Psychological/Emotional <input type="checkbox"/><br>Financial/Material <input type="checkbox"/><br>Discriminatory <input type="checkbox"/> |
| <b>LOCATION ABUSE TOOK PLACE</b><br>(please tick)   |   |
| Residential Care <input type="checkbox"/><br>Own Home <input type="checkbox"/><br>Hospital <input type="checkbox"/><br>Carer's Home <input type="checkbox"/>        | Nursing Home <input type="checkbox"/><br>Day Care <input type="checkbox"/><br>Community <input type="checkbox"/><br>Other (please specify) <input type="checkbox"/>           |
| Has consent been given from the service user to share information with other agencies? Yes/No   |   |
| Has consent for the investigation been given? Yes/No  |   |

### 4. Details of alleged perpetrator

|   |               |   |  |
|---|---------------|---|--|
| <b>FULL NAME</b>  |               | <b>ADDRESS</b>                          |  |
| <b>RELATIONSHIP TO SERVICE USER</b>                           |               | <b>POSTCODE</b><br><b>TELEPHONE NO.</b> |  |
| <b>DATE OF BIRTH</b><br>(approx age)                          | <b>GENDER</b> | Female/Male                             | <b>IF A SERVICE USER,</b><br><b>SWIFT NO. (if known)</b> |
| <b>Is the alleged perpetrator also a vulnerable adult?</b>    |               |   | Yes/No   |
| <b><i>Is the alleged perpetrator aware of this alert?</i></b> |               |   | Yes/No   |
| <b>Any other information relating to alleged perpetrator</b>  |               |   |  |

## 5. Continuity of Report of Information about the allegation

|   |           |
|---|-----------|
| <i>(Please fill out all that is applicable)</i>       |           |
| <b>Information about the disclosure received from</b> |           |
| FULL NAME   |           |
| TELEPHONE NO.   |           |
| DATE INFORMATION RECEIVED                             |           |
| RELATIONSHIP TO SERVICE USER                          |           |
| OTHER INFORMATION REGARDING DISCLOSURE                |           |
| <b>Any other witnesses regarding the incident</b>     |           |
| FULL NAME   |           |
| TELEPHONE NO.   |           |
| DATE INFORMATION RECEIVED                             |           |
| RELATIONSHIP TO SERVICE USER                          |           |
| OTHER INFORMATION REGARDING DISCLOSURE                |           |
| <b>Information about disclosure passed to</b>         |           |
| FULL NAME   |           |
| TELEPHONE NO.   |           |
| DATE INFORMATION RECEIVED                             |           |
| RELATIONSHIP TO SERVICE USER                          |           |
| OTHER INFORMATION REGARDING DISCLOSURE                |           |
|   |           |
| FULL NAME   |           |
| TELEPHONE NO.   |           |
| DATE INFORMATION RECEIVED                             |           |
| RELATIONSHIP TO SERVICE USER                          |           |
| OTHER INFORMATION REGARDING DISCLOSURE                |           |
|   |           |
| FULL NAME   |           |
| TELEPHONE NO.   |           |
| DATE INFORMATION RECEIVED                             |           |
| RELATIONSHIP TO SERVICE USER                          |           |
| OTHER INFORMATION REGARDING DISCLOSURE                |           |
|   |           |
| FULL NAME   |           |
| TELEPHONE NO.   |           |
| DATE INFORMATION RECEIVED                             |           |
| RELATIONSHIP TO SERVICE USER                          |           |
| OTHER INFORMATION REGARDING DISCLOSURE                |           |
| <b>FORM COMPLETED BY</b>                              |           |
| FULL NAME   | JOB TITLE |
| TELEPHONE NO.   | TEAM      |
| SIGNED  | LOCATION  |
| DATE  |           |

## 6. Action Taken or to be Taken

*When answering the following questions, please include dates where applicable.*

|   |  |
|---|--|
| <b>Have discussions taken place with other key professionals?</b><br>If yes, please tick all those involved | Yes/No   |
| Adult Social Care <input type="checkbox"/>  |  |
| Health Services (please specify) <input type="checkbox"/>   |  |
| CSCi <input type="checkbox"/>   |  |
| Commissioning <input type="checkbox"/>  |  |
| Police <input type="checkbox"/>   |  |
| Other (please specify) <input type="checkbox"/>   |  |
| <b><u>The police MUST be informed if you suspect that a crime has been committed</u></b>                    |  |
| <b>Has a PPU referral form been sent?</b>   | Yes/No   |
| <b>Have you contacted the PPU for advice?</b>   | Yes/No   |
| <b>Have you been given a Police reference number?</b><br>If yes, what is it?                                | Yes/No   |
| <b>Have you been given a Police crime number?</b><br>If yes, please specify                                 | Yes/No   |
| <b>Did you call 999?</b>  | Yes/No   |
| Has a Mental Capacity Act assessment been undertaken?   | Yes/No   |
| Has independent Mental Capacity Act Advocate been allocated?  | Yes/No   |
| Has an initial risk assessment been undertaken?   | Yes/No   |
| Has this referral been discussed with a Team Manager?   | Yes/No   |
| Has a Strategy discussion/meeting been held?  | Yes/No   |
| No further action required?   | Yes/No   |
| Referral to another agency?   | Yes/No   |
| Investigation required?   | Yes/No   |
| Please give details   |  |
| <b><u>Please fax completed form to the SVA team on 01296 383338.</u></b>                                    |  |
| Tel: 01296 382178   | E-mail: <a href="mailto:safeguardingadults@buckscc.gov.uk">safeguardingadults@buckscc.gov.uk</a> |
| Address: Room G41, County Hall, Aylesbury, HP20 1YU   |  |

## APPENDIX 7: RISK ASSESSMENT GUIDANCE

The following information can be used to guide decision-making regarding risk

### Risk assessment in adult protection

Clear and consistent risk assessment is essential in adult protection work to ensure an adequate and timely response to concerns. Risk assessment is not a one off event, but something that should inform decision-making at all stages of the adult protection process. This can include decisions about the following:

- Whether emergency action is required
- The level of seriousness and/or urgency in the situation
- What level of response is required under the inter-agency procedures
- Whether statutory powers are necessary to intervene in an adult's best interests
- The long term actions necessary to protect a person
- The level of monitoring and review required

Risk assessment at all stages of the process must be evidenced in case records

### The dimensions of risk in adult protection

Risk assessment requires the worker to consider three dimensions in relation to the case or presenting situation:

- 1) The **features of the abuse**/suspected abuse
- 2) **Situational Factors** (those relating to the environment/role of the abuser)
- 3) **Individual Factors** (those relating to the vulnerable adult).

The following gives guidance on each of these dimensions and how to assess the level of presenting risk. Cases of suspected abuse rarely present themselves clearly, information can be absent or confusing and **professional judgement will always be required**. Therefore these pages are designed not as a definitive guide, but to support discussion and decision-making in each individual case.

**1) Features of the abuse:**

The nature of the possible abuse and its apparent impact on the vulnerable adult (VA)

| <b>Features of possible abuse</b>                                | <b>High Risk</b>  | <b>Medium Risk</b>   | <b>Low Risk</b>  |
|--|---|--|--|
| <b>Physical impact</b>   | Deliberate assault or injury  | Injury, pain or ill-health due to inappropriate care   | Limited discomfort felt by VA  |
| <b>Psychological impact</b>                                      | VA frightened   | VA confidence and esteem affected  | Emotional needs of VA not recognised or met  |
| <b>Sexual impact</b>   | Sexual assault. Forced participation or viewing of sexual acts, including pornography                         | Inappropriate touching   | Insensitivity to VA's needs  |
| <b>Financial impact</b>  | Fraud or theft of large sum of money or property  | Misuse of money or property belonging to a VA  | Taking of small items of little significance to VA   |
| <b>Neglect impact</b>  | Life threatening or requiring medical attention   | Emotional or physical health affected by poor care   | VA's potential not fulfilled   |
| <b>Discriminatory impact</b>                                     | Abusive actions motivated by discrimination   | Refusing to meet specific needs  | Failing to meet specific needs, although unintentional   |
| <b>Institutional impact</b>                                      | VA's skills, decision-making or independence are severely compromised by service provision                    | Service provision limits VA's independence but skills and decision-making are retained                 | Service provision limits some independence   |
| <b>Timescale/Frequency</b>                                       | <b>High Risk</b>  | <b>Medium Risk</b>   | <b>Low Risk</b>  |
| The <b>timescale</b> and <b>frequency</b> of the suspected abuse | Abuse is recent (within four weeks) and has occurred more than once and/or there is a history of abuse for VA | Abuse is recent but only occurred once within the last 4 weeks and there is no history of abuse for VA | Abuse took place more than 4 weeks ago, nothing has occurred since and there is no history of abuse for VA |

## 2) Situational Factors:

Factors relating to the suspected perpetrator or the environment in which the suspected abuse is taking place

- **Power** – the power of the perpetrator from the perspective of the vulnerable adult  
*If a perpetrator has (or is perceived to have by the vulnerable adult) significant power over the individual, abuse is more likely to occur, less likely to be challenged or reported again, and more likely to cause significant harm*
- **Access** – the nature of access the perpetrator has to the vulnerable adult  
*If a perpetrator has unlimited or unsupervised access to a vulnerable adult, abuse is more likely to occur, less likely to be challenged or reported again, and more likely to cause significant harm*
- **Relationship** – the type of relationship between the perpetrator and vulnerable adult  
*If a perpetrator is providing intimate support, high levels of emotional support or has access to property or finances, abuse is more likely to occur, less likely to be challenged or reported again, and more likely to cause significant harm*
- **Other Vulnerable Adults** – the contact the perpetrator is likely to have with other vulnerable adults  
*If a perpetrator has, or could be able to gain, access to other vulnerable adults (for example as a result of their paid or volunteer role) the risk of abuse of other vulnerable adults is high*
- **Isolation** – the isolation of the vulnerable adult and their access to non-abusing contacts or those capable of advocating for them.  
*If a vulnerable adult is isolated and has contact only with the suspected perpetrator or abusing institution then abuse is more likely to occur, less likely to be challenged or reported again and more likely to cause significant harm*

**Examples of situational factors and their level of risk:**

| <b>Situational Factor</b>             | <b>High Risk</b>  | <b>Medium Risk</b>  | <b>Low Risk</b>  |
|---------------------------------------|---|---|--|
| Abuser's <b>POWER</b> over VA         | Seen to be in a powerful position by the VA   | Vulnerable adult is able & willing to contact someone with higher authority than the abuser | Stranger or brief contact  |
| Abuser's <b>ACCESS</b> to VA          | Unrestricted and unsupervised access  | Unrestricted access but supervised  | In group situations only, with others who could/would protect the VA           |
| Abuser's <b>RELATIONSHIP</b> with VA  | Provides intimate care/support or has unrestricted access to VA's finances/property | Provides support with activities of daily living  | Social contact only  |
| Abuser's contact with <b>OTHER VA</b> | Unsupervised access to other VAs  | Supervised access to other VAs  | Minimal contact with other VAs (no more than a member of the public)           |
| VA's <b>ISOLATION</b>                 | VA is isolated: contact only with abuser or abusing institution                     | VA has some contact with others apparently likely to advocate on their behalf               | Frequent and contact with others apparently likely to advocate on their behalf |

## Individual factors

Factors relating to the vulnerable adult's abilities and skills that can protect or exacerbate the risk of harm and exploitation

- **Communication Skills** – the ability of the individual to easily communicate concerns, worries, events etc.  
*If an individual has difficulty communicating verbally or relies heavily on others to interpret their communication, they are more likely to experience abuse, and less likely to be able to challenge it themselves or raise the alarm with others.*
- **Capacity** – the ability of the individual to make decisions for themselves about any particular issue  
*If an individual lacks capacity or has fluctuating capacity to make some decisions they are more likely to experience abuse, less likely to challenge it themselves or raise the alarm with others*
- **Dependency** – the extent to which the individual is reliant on others for their physical needs  
*If an individual is highly physically and/or emotionally dependent on others, they are more likely to experience abuse, less likely to challenge abuse themselves and less likely to raise the alarm with others*
- **Recognition of harm** – the extent to which the individual can understand their rights or interpret others' behaviour  
*If an individual has difficulty recognising the risk or interpreting the behaviour of others (they show complete trust in others), they are more likely to experience abuse, less likely to challenge it themselves or raise the alarm with others.*
- **Protective behaviour** – the extent to which the behaviour of the individual provides protection from harm and exploitation  
*If an individual displays behaviour that puts them at risk from others (e.g. seeking friendship at all costs, making repeated false claims, overt sexual behaviour etc) with no apparent consideration of how to cope with adverse situations or to protect themselves, then they are more likely to experience abuse, less likely to challenge it themselves or raise the alarm with others.*
- **Self confidence/esteem** – the extent to which the person has the emotional capacity to stand up for themselves and demand their rights  
*If an individual has low self confidence/esteem, they are more likely to experience abuse, less likely to challenge it themselves or raise the alarm with others*

**Examples of individual factors and their level of risk:**

| <b>Individual Factor</b>            | <b>High Risk</b>  | <b>Medium Risk</b>   | <b>Low Risk</b>   |
|-------------------------------------|---|--|---|
| VA's <b>COMMUNICATION SKILLS</b>    | Limited verbal communication skills, interpretation required by others  | Clear verbal communication skills, but can be easily misunderstood or ignored by others.   | Clear verbal communication skills with little chance for misunderstandings or misinterpretation by others   |
| VA's <b>CAPACITY</b>                | VA's capacity to make decisions is severely compromised   | VA can make decisions for themselves, but needs appropriate support and help to do so  | VA is able to make decisions for themselves and is able to easily source their own help and support to do so                                      |
| VA's <b>DEPENDENCY</b>              | Physically dependant on others for most of their intimate needs   | Physically independent, but requires some support (physical or emotional) for activities of daily living, or leaving the setting | Physically independent, able to leave the setting unaided, and able to manage activities of daily living with no/limited emotional support        |
| VA's <b>RECOGNITION OF HARM</b>     | No comprehension of risk and/or displays complete trust in others   | Feels that something is wrong with situation, and shows some understanding that others' behaviour can be abusive                 | Understands what abuse is and recognises that they have been abused   |
| VA's <b>PROTECTIVE BEHAVIOUR</b>    | Shows frequent behaviour that puts them at risk from others (either in reaction or through targeting) and no strategies to avoid adverse situations | Shows behaviour that puts them at risk from others, but has some strategies to avoid adverse situations                          | Does not show behaviour that puts them at risk from others <b>OR</b> displays clear strategies to avoid adverse situations and protect themselves |
| VA's <b>SELF CONFIDENCE/ ESTEEM</b> | VA indicates that they do not deserve to live a life free from abuse and/or displays no awareness that things could or should be different          | VA indicates that they want and deserve to live free from abuse, but unsure how to achieve this                                  | Indicates that they deserve to live a life free from abuse, knows how to achieve this and can access required support services                    |

**Risk assessment template for individual cases**

|   |  |  |
|---|--|--|
| <b>Name:</b>                                    |  | <b>Swift ID:</b>   |
| <b>Factor</b><br>Abuse, Situational, Individual | <b>Level of risk</b><br>Low/Medium/High/Unknown/NA | <b>Key information relating to risk</b><br>information leading to judgement of level of risk |
| <b>Features of the possible abuse</b>           |  |  |
| Physical impact                                 |  |  |
| Psychological impact                            |  |  |
| Sexual impact                                   |  |  |
| Financial impact                                |  |  |
| Neglect impact                                  |  |  |
| Discriminatory impact                           |  |  |
| Institutional impact                            |  |  |
| <b>Frequency of possible abuse</b>              |  |  |
| The timescale/frequency of abuse                |  |  |
| <b>Situational factors</b>                      |  |  |
| Abuser's <b>power</b>                           |  |  |
| Abuser's <b>access</b>                          |  |  |
| Abuser's <b>relationship</b>                    |  |  |
| Abuser's contact with <b>other VA</b>           |  |  |
| VA's <b>isolation</b>                           |  |  |
| <b>Individual factors</b>                       |  |  |
| VA's <b>Communication</b>                       |  |  |
| VA's <b>Capacity</b>                            |  |  |
| VA's <b>dependency</b>                          |  |  |
| VA's <b>recognition of harm</b>                 |  |  |
| VA's <b>protective behaviour</b>                |  |  |
| VA's <b>self-esteem/confidence</b>              |  |  |
| <b>Actions to be taken to reduce risks:</b>     |  |  |
|   |  |  |

## **APPENDIX 8: INVESTIGATION ROLES AND RESPONSIBILITIES** *Including achieving best evidence guidelines*

In many cases, specific roles and responsibilities around safeguarding investigations will fall to staff within Bucks CC or designated staff in other partners. This appendix provides more specific guidance for staff fulfilling those roles. It is divided into the following sections:

- a) Strategy meeting guidance, including attendance checklist
- b) Minute taking guidance for administrators
- c) Investigation guidance (including Achieving Best Evidence interviews)
- d) Case conference guidance/checklist
- e) Protection planning guidance/checklist
- f) Investigating manager's role
- g) SWIFT guidance

### **Strategy meetings**

The **objectives** of a strategy meeting are as follows:

- To ensure effective multi-agency work by involving people from key agencies;
- To facilitate the sharing of information between agencies;
- To reach a shared view about how serious the alleged abuse may be;
- To establish a common understanding about the overall breadth of the investigation required;
- To agree tasks and timings for each stage of the investigation;
- To plan jointly how to carry out the investigation and prepare an action plan;
- To agree a way of monitoring/reviewing the implementation of investigation plans;
- To identify and implement an emergency protection plan to safeguard any vulnerable adult pending the outcome of an adult protection enquiry. This should be moved to best practice;
- To set a provisional date for a case conference.

The **content** of the strategy meeting should include the following:

- What are the wishes, if known, of the vulnerable adult involved
- Has he/she given permission to involve other agencies
- Is there a need to break confidentiality
- Is there a need to consider the continuing safety of the vulnerable adult? For example, is there a need for immediate protective action either on a voluntary basis or through the courts
- Whether the allegation requires the participation of the Police in order to safeguard evidence.
- In criminal investigations, the vulnerable adult should be considered for Achieving Best Evidence interviews in accordance with the procedures
- Is there a need for a medical examination?
- How can information about the vulnerable adult best be gathered?

- Is it possible that there are other victims?
- Who should be interviewed, what is the best place and time for interviews?
- Who is best placed to conduct the investigation? (Should a worker known to the vulnerable adult/carers/family undertake the investigation or any interviews, or should a 'neutral' worker do this and should tasks be shared by more than one worker?)
- When and how should the alleged perpetrator be made aware of the allegations. Consideration will also need to be given as to who is best placed to notify them of this investigation.

#### *Involvement of vulnerable adult/s and their carers*

- When and how should the vulnerable adult and/or their carers be involved in relevant meetings? How does their current level of distress affect their involvement? Should they be present at meetings or are there other ways they can contribute to decision making
- What practical assistance would facilitate the vulnerable adult's involvement and co-operation; for example, transport to a clinic and interviews, assistance with childcare arrangements?
- What personal support do families need; for example, links with support groups, separate workers for different family members?
- What arrangements should be made to facilitate the involvement and contribution of vulnerable adults with disabilities; for example, conducting interviews in buildings with easy access, the use of interpreters and specialist staff?
- Are there issues of race, culture, language or gender that require special arrangements to be made?

#### **Who should attend or participate in a strategy meeting or discussion?**

This list is not exhaustive but includes a suggestion of the range of individuals who may be included in a strategy meeting/discussion:

- Chairperson (Investigating Manager)
- Minute taker
- Police
- Senior Practitioner
- Investigating Officer
- Achieving Best Evidence Interviewer
- General Practitioner
- Community/Psychiatric Nurse
- RNCC Nurse Assessors
- CQC Manager
- CQC/Healthcare Commission
- OT/Physiotherapist
- Home Care representative
- Day Care representative
- Housing representative
- Residential/Nursing home representative
- Voluntary organisations

- Contracts Unit
- Crown Prosecution Service
- Court of Protection
- Trading Standards
- Human Resources/Personnel specialist
- Advocate/IMCA

**Provider service invitations:** Unless the manager/owner of a provider service is or may be implicated in the allegations, it is good practice to include them in discussions at the earliest opportunity. If this is not the case it should be recorded why this inclusion was not considered appropriate. Private, voluntary and independent sector care providers are to be welcomed as partners in assisting in the investigation process.

**GP invitations:** Where there are any health concerns arising from the safeguarding adults referral the individual's GP should automatically be invited and this should be recorded.

### **Content of strategy notes**

The strategy meeting/discussion record should include details of the following:

- Why the adult is considered vulnerable
- What allegations have been made and by whom
- Any perpetrator(s) by relationship (not by name), i.e. paid home carer or relative.
- Whether immediate action to reduce risk has taken place, e.g. staff member suspended.
- Where abuse took place, (inc. does it involved a registered service)
- Who are the significant people involved with the vulnerable adult
- What action has been agreed to continue the investigation and by whom it will be carried out, including timescales.

### **Staff welfare at strategy meetings**

Details and photographs of injuries/ victim may be distressing for those discussing issues and planning the next steps. The chair of the strategy meeting/discussion should give consideration to the debriefing of any staff member involved in this process. Occupational Health services or intensive supervision meetings may be arranged.

### **Minute taking guidance for administration staff**

This guidance identifies issues that an administrator may need to consider when asked to minute-take a safeguarding adults strategy meeting or case conference. The list is not exhaustive but aims to provide a comprehensive framework. The Minute Taker should be identified by the safeguarding adults Investigating Manager in consultation with their direct line manager once it is identified that safeguarding

### **Preparation/pre-briefing**

- Compile details of those to be invited to attend, (name/address/agency).
- Invitations sent with sufficient notice of strategy meeting/discussion or case conference date. Always liaise with the Investigating Officer before sending an invitation to the Service User or Carer. Ensure letters are marked as 'Private and Confidential' and use the standard letter template.
- Collate a participant list.

- Obtain background of case.
- Collate and photocopy reports to be presented at case conferences, ensuring pages are numbered.
- Plan your time and your service manager's time to ensure a pre-briefing, debriefing and to produce 'first draft' soon after the conference. Book a quiet office for typing up the notes.
- Meet with the chair prior to meeting to agree the structure of the meeting and anticipate content.
- Arrange practical aspects of meeting: waiting room/area; pens and paper for participants, seating arrangements; name labels; refreshments
- Clarify with the chair what arrangements s/he will put in place to ensure you are able to keep track of the conference and maintain accurate notes (e.g. can you interrupt or 'signal' to the chair you need a moment to clarify or catch up).
- Make a note of acceptances, apologies and those not replied and pass a copy to the Chair.
- Familiarise yourself with the names/details of those likely to attend.

### **During the meeting**

- Sit in such a way as to ensure you can communicate with the chair (ideally next to them).
- Introductions should include you, the role you fulfill, and any considerations you (or the chair) have made to help keep a good record.
- Follow the guidelines for writing your report when taking notes of the meeting.
- Make use of reports provided to the case conference (you won't need to repeat this information).
- If you get lost, let the chair know you are having some difficulty.
- Do not participate in the discussions, but you can ask questions to clarify your record such as: Who would you like that recorded? Do you want that recorded?
- Ensure that any follow up meetings are agreed and that a note is made of any date, time and likely venue mentioned.

### **Debrief after the meeting**

- Check and clarify your notes. Make sure you both agree and are clear about the discussions and any action that is to be taken (it is also an opportunity to discuss any emotional impact the meeting may have had for you).
- Ensure that any additional papers circulated at the meeting are forwarded to the minute taker electronically for further circulation.
- Produce a first draft for the chair as soon as possible after the meeting (ideally within 1 working day) using the appropriate recording form.
- Chair agrees the minutes are to be circulated. Protect the final version of documents against changes before sending out electronically.
- Liaise with the Investigating Officer regarding circulation of notes to Service User and/or Carer, ensuring any information not shared at the meeting is not included in the minutes.

- Clarify timescales for circulating the minutes to participants and responding to any amendments subsequently requested (chair agrees these).
- Retain your hand written notes of the case conference until the final version has been agreed by the chair and participants.

### **Content of the minutes**

The form used will give guidance on the areas to be recorded and give prompts for the information required. The information must include the following:

- Record of attendance
- Apologies and details of any reports submitted in lieu of attendance
- Those not present but that were invited
- Purpose/focus of the case conference
- Factual information provided by participants (don't need to duplicate information in reports)
- Dispute of facts (who, what)
- Agreed level of investigation (Level 1, 2, 3 or 4)
- Opinions
- Analysis
- Summary
- Any dispute of analysis
- Recommendations and reasons for recommendations (if there are any disagreements note these)
- Conclusions/actions
- Review date.

### **Investigation guidance (including Achieving Best Evidence interviews)**

The following information contains guidance for conducting investigations into abuse allegations. **It is vitally important that, when a criminal offence might have taken place, a referral is made to the police at the earliest possible opportunity.** Failure to do so could contaminate evidence and reduce the chances of a successful prosecution, regardless of whether this investigation guidance has been followed.

#### **Planning the investigation**

Whatever the level of response, consideration of the following points, prior to commencing the investigation will help inform the decision making process and ensure the investigation is conducted in an effective and timely manner. The rationale for any decisions made on these issues must be recorded:

- The possible involvement of the police; if they are already involved in the investigations, care must be taken not to jeopardise any action they may wish to take
- The need for medical examinations.
- The urgency of the situation and whether an immediate visit to the vulnerable adult is needed
- The degree of risk to the vulnerable adult, including:

- The risk of repeated or escalating acts involving the vulnerable adult or other vulnerable adults
- The extent of the abuse
- The length of time abuse has been occurring
- The impact on the individual's wellbeing
- Who should be interviewed
- Where will interviews take place
- The sequence of interviews
- Who will conduct the interviews?
- Whether an Achieving Best Evidence Interview is appropriate (see below).
- The purpose of any interviews.
- The vulnerable adult's capacity to make decisions. This should follow Mental Capacity Act guidance. It is important to note that a person may still be able to provide evidence and useful information, even if their capacity is doubtful in other decision-making areas
- The rights and wishes of those people involved
- The legal framework under which further enquiries could be pursued;
- Consideration of the need to carry out an investigation in tandem with other procedures, assessments and investigations. This includes the following:
  - Criminal investigation
  - Mental Health Act Assessment
  - Care Programme Approach Assessment/Review Meeting
  - Complaints Procedures
  - Disciplinary Procedures
  - Contracts Monitoring Procedures.
- Consideration should be given to whether alerting the person alleged to have carried out the abuse might further jeopardise the safety of the vulnerable adult or the collection of evidence.
- Consideration of other sources of evidence, including written records, statements from witnesses, forensic and medical evidence.
- Decisions about who should be informed about the alleged abuse need to be made; in particular any agencies involved with the vulnerable adult need to be informed. It will be appropriate, usually, to inform family, or significant adults about the alleged abuse, with the consent of the vulnerable adult.
- If the person alleged responsible for the abuse is themselves a vulnerable adult, the investigation should ensure an assessment of their needs is undertaken. A separate case conference may need to be convened.

## Achieving Best Evidence Interviews (Investigations when the police are involved)

If there is any possibility that a criminal offence may have been committed, the vulnerable adult should not be interviewed alone or in the presence of the person alleged to be responsible for the abuse. In such cases a referral to the police must be made and consideration given to whether an achieving best evidence interview is appropriate, in which the vulnerable adult may require the following:

- An 'appropriate' adult under the Police and Criminal Evidence Act (1984);
- Special measures for recording and giving evidence (video evidence in particular);
- An independent advocate;
- A member of their family or close friend, if this is deemed appropriate.

In these circumstances it is good practice to interview vulnerable and intimidated witnesses, (both adults and children), in a way in which to enable them to give their best evidence in criminal proceedings. Guidance exists on preparing and planning for interviews with vulnerable and intimidated witnesses, decisions about whether or not to conduct an interview and decisions about whether the interview should be video recorded or whether it would be more appropriate for a written statement to be taken. This guidance is intended for all persons involved in relevant investigations including the Police, Social Workers and member of the legal profession.

Not all "vulnerable adults" as defined in this policy will necessarily be vulnerable witnesses and would not wish to be treated as such. This is recognised in the definitions and criteria contained in the Youth Justice and Criminal Evidence Act 1999. Those adults who are eligible for consideration for **Special Measures** fall into two groups, defined in Sections 16 and 17 of the 1999 Act. The first group comprises those who have a disability or illness that the court considers is likely to affect the quality of their evidence. The second group consists of those who because of age, personal circumstances and the nature of the alleged offence, may also qualify for Special Measures if the court is satisfied that the quality of their evidence is likely to be diminished by reason of their fear or distress. It is the CPS who will determine whether special measures are required rather than an individual police officer.

In reaching a decision on whether the Special Measures should be invoked, the courts must take account of the wishes of the individual witness. It is imperative therefore that investigators establish at an early stage whether the adult witness is likely to qualify for a Special Measures direction under the 1999 Act and if so, what particular measures, if any, will assist the witness to maximise the quality of their evidence. This will need to be discussed with the witness to ascertain their views. It is essential that the Police, social care agencies, the prosecution or defence and court officials take account of the individual circumstances of each witness, together with their expressed needs and wishes, in order to provide support sufficient to enable all witnesses to give their best evidence.

## Carrying out an interview

The following information provides guidance on how to carry out an interview as part of a safeguarding adults investigation. This could be one carried out under ABE (as outlined above) or part of an investigation that does not include criminal considerations.

During the interview the Investigating Officer should ensure that:

- Information about his/her designation and the agency he/she represents is stated clearly;
- The purpose of the interview is made clear
- The nature of the allegation is identified
- How the interview is carried out is explained
- A relaxed and caring manner is adopted
- An attempt is made to establish how the alleged abuse occurred
- Any signs of injury, the explanation given for the cause of the injury, and the general condition of the vulnerable adult are noted
- An initial assessment of the needs of the vulnerable adult together with a social history is made
- Support networks are in place for the vulnerable adult;
- The risks are assessed;
- Attention is paid to the indicators of abuse;
- Consideration is given at every stage of the investigation as to whether police involvement and/or medical assessment or treatment is required.

At the end of the interview the Investigating Officer should ensure that the following points are covered:

- A clear review of what has happened
- A statement that the Investigating Officer is required to consult with the investigating Manager in order to make decisions
- Clear information about any agencies who will be involved at this stage (e.g. police, doctor)
- The value of any support which can be provided, and if accepted when it will come into effect.

## A suggested framework for carrying out an interview

(Based on the Home Office Memorandum of Good Practice 1992)

| <b>Phase 1: Rapport</b>   |
|---|
| <b>Purpose</b> <ul style="list-style-type: none"><li>• To settle the person and relieve their anxiety</li><li>• To supplement interviewer's knowledge of the person, especially their communication style and level, and the scope of their vocabulary</li><li>• To explain reason for the interview</li><li>• To remind the person to speak the truth.</li></ul> |
| <b>Approach</b> <ul style="list-style-type: none"><li>• Any topic that relaxes the person</li></ul>   |
| <b>To be Avoided</b> <ul style="list-style-type: none"><li>• Any mention of the alleged incident, staring at or touching the person at any time</li></ul>   |
| <b>Additional Comments</b> <ul style="list-style-type: none"><li>• This phase may need to be repeated at several points in the interview and should an interview never start without it.</li></ul>  |

| <b>Phase 2: Free Narrative Account</b>  |
|---|
| <b>Purpose</b> <ul style="list-style-type: none"><li>• To enable the person to given an account in their own words.</li></ul>   |
| <b>Approach</b> <ul style="list-style-type: none"><li>• Provide opportunities to talk about alleged incident at the person's pace</li><li>• Use a form of 'active listening'.</li><li>• Begin by asking the person to tell you about the event in question, without interrupting, or asking for further information.</li><li>• Use "TED" questions: Tell me; Explain; Describe to prompt if required.</li><li>• Example: "Tell me about the day X happened"</li></ul> |
| <b>To be Avoided</b> <ul style="list-style-type: none"><li>• Questions directed to events not mentioned by the person</li><li>• Interrupting the person or speaking as soon as person appears to stop</li></ul>   |
| <b>Additional Comments</b> <ul style="list-style-type: none"><li>• Be patient If nothing related to alleged offence is mentioned, consider moving to Phase 4.</li></ul>   |

### Phase 3: Questioning

#### Purpose

- To find out more about alleged incident

#### Approach

- Questions graduating from general to more specific as outlined below 3a-d

#### To be Avoided

- Interrupting the person, even to clarify language
- repeating a question too soon
- using difficult grammar / sentence constructions
- asking more than one question at a time

#### Additional Comments

- Consider at each stage of questioning whether it is in the interests of the person to proceed further
- You should always return to the earlier stages of questioning when possible (i.e. use a TED approach to follow up on a comment, before using a more narrowly focused question).

### Phase 3a-d: Types of Questions

Open ended questions should always be used whenever possible and you should revert back to these type of questions when moving to a new detail or clarification.

#### 3a) Open Ended Questions

- These can be used to encourage free narrative or to prompt a person to say more about a particular issues
- TED questions (Tell me; Explain; Describe)
- Example: "You said you were frightened, tell me more about that"

#### 3b) Specific Closed Questions

- These questions ask for extension or clarification and close down an interviewee's response, but in a non-suggestive way.
- 5WH questions (Who, What, When, Where, Which, How)
- Example: "Who was in the room when X happened?"
- You should avoid the question "why" as this can be interpreted as apportioning blame

#### 3c) Forced Choice Questions

- These are questions that provide the interviewee with a limited number of alternative responses. Providing the questions offer a number of sensible and equally likely alternatives they would not be considered leading questions.
- Some vulnerable people may find these questions very helpful, but avoid using questions with only two alternatives
- Always ensure that there is an option for "none of the above", otherwise someone may answer because they feel they have to
- Example: "was the man's jacket red, some other colour, or you can't remember?"

#### 3d) Leading Questions

- Leading questions are questions that imply the answer or assume facts, (For example, “Where did he hit you?” when the interview themselves has not used the word “hit” previously in the interviewer.
- They should be avoided whenever possible, and advice should always be sought from a second interviewer if it is likely they may have to be used. Responses to leading questions have limited evidential value, so all alternatives should be explored before resorting to them
- Remember that individuals with limited communication may be able to communicate non- verbally using visual means (such as a picture board) and so these methods can be used to provide forced choice-questions in preference to leading “yes or no” questions.

#### **Phase 4: Closing the Interview**

|   |
|---|
| <b>Phase 4: Closing the Interview</b>   |
| <b>Purpose</b> <ul style="list-style-type: none"> <li>• To ensure the person has understood the interview and is not distressed.</li> </ul>   |
| <b>Approach</b> <ul style="list-style-type: none"> <li>• Go over relevant evidence in person’s language;</li> <li>• revert to rapport topics</li> <li>• thank person and allow person to ask questions</li> </ul> |
| <b>To be Avoided</b> <ul style="list-style-type: none"> <li>• Summarising in over-complicated language or using jargon that the person does not understand.</li> </ul>  |
| <b>Additional Comments</b>  |

### **Investigation Reports**

An investigation report should be produced by the Investigating Manager: For **Level 3 & 4** investigations, the report should cover the following areas:

- Details of the initial alert
- Outline of the current allegations and any previous allegations
- An assessment of the seriousness of the alleged abuse
- Location of the abuse
- Possible causes of the abuse
- Background information about the vulnerable adult
- Issues and opinions relating to consent and capacity
- Social situation/network of the vulnerable adult
- Information about the person alleged responsible (if applicable)
- A description of the investigation process (what was involved) and the level of co-operation received from the various people involved
- Presentation and evaluation of the evidence;

- A view about future risks
- Recommendations about future action required.

For **Level 1** investigations, a report should be produced by the manager of the service and sent to the Investigating Manager. The report should contain the following:

- Details of the service user(s)
- Summary of presenting concerns
- Summary of investigation, including those consulted, including discussions with the service user and carers
- Details of action to address concerns
- Outcomes of the actions and who was notified
- Service user's views of the investigation and outcome – note of when the service user was informed about the allegation and their view on what should happen in the future should also be recorded
- Copies of any relevant documents about the matter held by the service, e.g. incident/accident reports
- Date, name and signature of the manager.

### **Case conference guidance/checklist**

#### **Guiding Principles for Case conferences**

- In some circumstances at Level 1 and 2 where co-operation from partners is required, it is good practice to consider holding a case conference to put together a formal plan.
- For all Level 3 and Level 4 investigations case conferences should always be held to complete the investigation and to agree the protection plan, unless there is clear evidence (recorded), as to why this course of action was not taken..
- The conference will treat the welfare of the adult as central to the decisions taken, including the racial, linguistic, cultural and religious needs and differences of the vulnerable adult.
- All those providing information should take care to distinguish between fact, observation, allegation and opinion.
- The views of each of the participants will be treated with respect.
- The vulnerable adult subject to considerations of capacity should be given every opportunity to attend if he/she wishes and to bring or nominate an advocate, friend or supporter. Where this attendance is likely to cause further distress or would be unhelpful, appropriate advocacy should be provided. This could be the worker working mostly closely with the adult who should ascertain what his/her wishes and feelings are, and make these known to the conference and feedback to them following the meeting.
- Informal carers, health/social care agency representatives and the GP will normally be invited to attend the case conference. If they are unable to attend, their views should be represented to the conference.
- The main proceedings and decisions of the meeting will be recorded in the prescribed form and will be circulated within 10 working days.

- The focus of the case conference is the vulnerable adult. Other adults or children in the household may also be the subjects of individual consideration regarding the risk of harm to them.

### **Attendance at case conferences**

The person responsible for calling the adult protection conference should:

- Explain the reason for the conference to the vulnerable adult/carers
- Consider ways in which the adult's view is best articulated
- Ask the vulnerable adult if they want anyone to attend the conference on their behalf
- Outline the conduct expected by all participants
- Include Trade Association representatives at the request of the service provider.

### **Attendance by the vulnerable adult**

Irrespective of capacity, every effort should be made to involve and include the vulnerable adult in the case conference. If, for whatever reason, the vulnerable adult is unable or unwilling to attend, consideration must be given as to how their views will be represented at the case conference.

If they do not wish to attend or nominate someone else, the conference should be provided with a clear and up to date account of their views by the professionals who are working with them. The conference should, therefore, expect the key worker to be able to inform them about the views of an adult who is not attending the meeting. The adult should be kept informed of the progress of the interagency work by the professional working with him/her.

### **Attendance by professionals**

The size of the professional group should be limited to those who really need to attend and name badges should be worn. It is considered good practice to include service providers in discussions at an early stage but

the involvement of individual care providers should be carefully planned and they should be prepared for the conference by the Investigating Officer.

### **Role of chairpersons of case conferences**

Case conferences will be chaired by an investigating manager from Bucks CC Adults and family Well Being, Community Mental Health Teams or Community Learning Disability Teams (this needs to be clarified) with the appropriate skill and experience to chair conferences. The status of the Chair should be sufficient to ensure inter-agency commitment to the conference and the protection plan. Wherever possible, the same person should also Chair subsequent safeguarding reviews of a specific adult.

The responsibilities of the Chair include:

- If the service user, carer or advocate is attending the meeting, the Chairperson should welcome them prior to the meeting and explain proceedings.
- To set out the reason and purpose of the conference to all present, and emphasising the confidential nature of the occasion.
- To enable all those present, and absent contributors, to make their full contribution to discussion and decision-making, curbing interruptions where necessary

- To note omissions and incomplete areas of investigation
- To ensure that a decision based on a balance of probability is taken regarding whether abuse occurred, did not occur, or that the evidence is inconclusive
- To summarise the information shared at the conference and consider the level of risk for the adult(s) concerned.
- To ensure that the conference takes the decision required of it, in an informed and objective way and this is recorded under the auspices of the multi-agency safeguarding adults procedures in line *with No Secrets (2000) Section 7 guidance*.

### **The role of case conference participants**

In addition to the Chair, other participants have responsibilities:

- The Investigating Officer should provide the conference with a written report, summarising and analysing the information obtained in the course of the investigation.
- Professionals attending the conference will bring with them full information of their involvement with the adult.

### **Content of the case conference**

A case conference should contain the following elements:

- The context in which the harm has occurred, the nature of that harm and its effect on the adult and whether the adult is at continuing risk of significant harm.
- The level of future risk to the vulnerable adult, including the following aspects of vulnerability and resilience:
  - Mental and physical health
  - The level of dependency and vulnerability
  - Behaviour
  - Access to support services
  - Social network, isolation or support; peer and social relationships
  - Opportunity to fulfill their potential
  - Giving basic care
  - Ensuring safety and protection
  - Providing emotional warmth and stimulation
  - Guidance and boundaries
  - Stability and consistency
  - Carer's health
  - Social/environmental factors
  - Financial management
  - Housing
  - Domestic abuse and substance misuse
  - The wider family
  - Family functioning

### **Minutes of the case conference**

The conference record is confidential and may only be distributed to those attending or invited to attend. In addition, circumstances may require that copies are also sent to other appropriate individuals with the agreement of the Chair (e.g. to the Head of Service – Safeguarding Adults; Coroner; or Health & Safety Executive).

The conference Chair should sign and date the case conference notes and they should be distributed within 5 working days. Each agency has responsibility for ensuring that any amendments should be sent in writing to the Chairperson within 10 days of receipt of the minutes and should ensure accuracy of the record of the conference, and not additional information or a change of view. It is the responsibility of the Chairperson, where amendments are submitted, to ensure that these are circulated and form part of the ongoing case conference record.

The record should include:

- A list of those who attended and apologies received
- Details of the vulnerable adult and their formal or informal carer(s)
- Who chaired the conference
- The reason why the conference was called
- Times of attendance where representatives have only attended part of the meeting
- The essential facts of the case
- An account of the discussion at the meeting which accurately reflects all contributions
- All decisions reached, with information outlining the reasons for decision
- A translation of decisions into an action/adult protection plan enabling everyone to be clear about their tasks
- Information provided by each professional attending, ensuring that fact and opinion are separate and that it is clear which adult is being referred to
- The vulnerable adult's view point
- Any further concerns raised
- A summary of discussions and conclusions
- A risk analysis by the Chairperson
- Recommendations (i.e. proposals for assessment, action/protection plan)
- Whether consideration was given to taking legal advice
- Any dissenting views should be recorded with clear indication of the dissenter(s) and the reasons for dissent
- The date for the next meeting including time and venue if possible.

## Protection planning guidance/checklist

### ***Having decided whether or not a case conference is required, consider:***

1. Has it been confirmed that abuse of a serious nature has taken place, is suspected of having taken place, or that there is a risk it may take place in the future?
2. What actions need to be taken to prevent future abuse and support the Vulnerable Adult post abuse?
3. Who would be best placed to implement actions and tasks agreed?

Where more than one organisation or more than one person will be required to perform a task as part of the overall plan. Good practice would dictate that a case conference is held in order to:

- formally confirm who is responsible for the actions agreed
- agree how information will be shared and set times deadlines to complete tasks.

Having agreed the elements of the plan, and how and who will implement the plan, it will also be necessary to

- ensure that formal reviews and monitoring arrangements have been agreed, and the time scales for these.

### ***A case conference will always take place when one of the following also applies:***

- The adult who has experienced abuse has capacity, and has agreed to or asked for a case conference/protection plan meeting to organise support to protect them.
- The adult does not have capacity to decide about their protection, or their consent is overridden by the duty of a partner organisation to protect them from abuse.
- Any agency involved with the provision of care to the vulnerable adult has asked for case conference/protection plan.

| PROTECTION PLANNING GUIDANCE/CHECKLIST  | TICK | COMMENT |
|---|------|---------|
| Formulate a Protection Plan including contingencies for a sudden change in circumstances, to which all attendees agree (including the victim if present), with key roles for agencies, and time scales set. |      |         |
| Decide which manager will be accountable for the delivery of the protection plan.   |      |         |
| Decide on the key worker who will implement this plan   |      |         |
| Confirm when the protection plan will be monitored and reviewed.  |      |         |
| Set date and time for Review Case Conference if appropriate.  |      |         |

Continued

| PROTECTION PLANNING GUIDANCE/CHECKLIST  | TICK | COMMENT |
|---|------|---------|
| <p>Take full minutes at the meeting and send copies of the minutes and the separate protection plan within 7 days to:</p> <ul style="list-style-type: none"> <li>• all participants</li> <li>• Practice Supervisor for Adult Protection</li> <li>• Principal Officer with lead for Adult Protection who will monitor the progress of the Protection Plan and timescales for reviews.</li> </ul> |      |         |
| <p>Obtain the signature of the vulnerable adult to confirm they are in agreement with the protection plan. If the person does not have capacity, then the relevant person advocate or LPA/ Deputy should agree and sign of their behalf</p>   |      |         |
| <p>If a case conference is not held, a copy of the care plan/protection plan must be given to the vulnerable adult and, if appropriate, their carer, and all other agencies with involvement with the vulnerable adult.</p>   |      |         |

**The content of the protection plan might include the following services:**

- Protection from contact with the perpetrator, in the first instance by measures, which remove the perpetrator from the situation.
- Access to legal remedies for protection.
- Security measures such as door locks, personal alarms, telephone/ Mincom, CCTV.
- Advocacy and support services.
- Activities that increase people’s ability to protect themselves.
- Services which improve self-esteem and confidence.
- Counselling and therapeutic services.
- Services that support the vulnerable adult and promote independence to enable them to remain in a community of their choice.
- Each protection plan should contain contingencies to cover a situation where there is a sudden change of circumstances for the vulnerable adult. For example acute hospital admission. The manager and or worker named as responsible for the implementation and monitoring of the protection plan should ensure that the hospital ward staff are aware of any risks posed by the transfer of the vulnerable adult to hospital. This may also be the case where a vulnerable adults needs to go into residential care urgently.
- The Protection Plan should not be part of the minutes of the Case Conference, but a separate document.

The signature of the vulnerable adult should be sought to confirm they are in agreement with the protection plan. If the person does not have capacity, then the relevant person advocate or LPA/ Deputy should agree and sign of their behalf.  
 Full minutes should be taken at the meeting and copies sent to all participants, within 7 days.

## **Investigating Manager's role**

The primary responsibility for managing the investigation process rests with managers of:

- Adult social care department assessment teams;
- Community mental health teams;
- Community learning disability teams;
- Safeguarding Adults team
- Other multi-agency teams

Investigating managers are responsible for ensuring that all appropriate agencies are involved in the investigation, that support is provided to the Investigating Officer, and good standards of practice are maintained. In addition, maintaining effective working relationships between agencies is essential. Managers will provide the first line of negotiation if working relationships are not effective and issues arise between agencies. Where there is a criminal investigation this will take precedence and be led by the police.

### **Specific responsibilities of investigating managers**

The investigating manager has individual responsibility for the overall coordination and performance of the investigation. This will require the manager to ensure that all of the following investigation elements are completed effectively and in line with the timescales set down in this document, namely:

- Consideration of the initial referral and any perceived risk
- Identification of the appropriate level of response
- Identification of necessary resources
- Allocation to an investigating officer
- Holding of a strategy meeting or discussion
- Planning of the investigation
- Informing of senior managers where necessary
- Liaison with other agencies
- Case conference
- Protection plan
- Monitoring and review requirements
- Closing the investigation & signing off the investigation as closed
- Recording and sharing of notes
- Sharing significant lessons learned with line managers, for line managers to notify to the Safeguarding Board and relevant sub committees

### **Supervision and support**

It is essential that Investigating Manager, Investigating Officer and administrative staff receive the appropriate support and supervision on any Safeguarding Adults investigation. Individual needs are likely to be identified by their line-manager.

It is the responsibility of the Investigating Manager to ensure that this is provided in a way that is appropriate to the experience of those involved and the complexity of the investigation. Supervision should be provided at least weekly. All case records must be seen by the Investigating Manager and countersigned where appropriate.

### **Health and safety of staff**

The Investigating Manager needs to ensure that health and safety issues are considered throughout the investigation.

## **APPENDIX 9: SAFER EMPLOYMENT PRACTICES**

Safer employment practices guidance can be found on  
Skills for Care website

[www.skillsforcare.org.uk/entry\\_to\\_social\\_care/recruitment/SME\\_toolkit.aspx](http://www.skillsforcare.org.uk/entry_to_social_care/recruitment/SME_toolkit.aspx)