Multi-Agency

Safeguarding Vulnerable Adults

Adult Protection Policy

Protocols and Guidance

for Kent and Medway

Amended January 2014

- Kent County Council Families and Social Care Directorate
- Medway Children and Adults Directorate
- Clinical Commissioning Groups and Health Trusts in Kent and Medway
- Kent Police
Dear Colleague

Re: Revised Kent & Medway Multi Agency Adult Protection Policy, Protocols and Guidance

I am delighted to introduce the latest revised version of the Kent & Medway Multi Agency Adult Protection, Policy, Protocols and Guidance.

The contents of the document are reviewed on a six monthly basis by the multi agency review group. Agreed changes and a separate record of amendments are posted on the Kent.gov and Medway.gov websites on the 31 January and 31 July each year.

The separate amendments section provides details of all the changes made to the original documents produced in May 2005. The amendments records refer to the named and numbered sections of the policy, protocols and guidance document.

It will be the responsibility of the recipient of this document to ensure that their copy of the document is kept up to date with any changes from the website.

Yours sincerely

Andrew Ireland
Corporate Director Families and Social Care (KCC)
Chair of the Kent and Medway Multi-Agency Safeguarding Board
Introduction

and Contents
Foreword

The 'No Secrets' DOH guidance, March 2000 was issued under Section 7 of the Local Authority Social Services Act 1970. It places a responsibility on social services to play a co-ordinating role in developing local policies and procedures for the protection of vulnerable adults from abuse. In addition, it states that other statutory agencies should 'work together in partnership to ensure that appropriate policies, procedures and practices are in place and implemented locally'.

The following document has been developed to meet the requirements of 'No Secrets' and to support good practice in adult protection. During consultations with all stakeholders a wide range of issues and questions were raised. The document aims to clarify issues and to answer questions raised.

The document is divided into three sections:

Part 1 The Policy identifies various aspects of abuse and the priority given to adult protection.

Part 2 The Protocols aim to clarify and support the roles and responsibilities of practitioners and managers in all agencies caring for vulnerable adults.

Part 3 The Guidance provides information about preventative strategies, about the law and about good practice.

The lead agency for adult protection across Kent and Medway is the agency with social services responsibilities for the client group concerned. In the interests of simplicity the agency with social services responsibilities will be referred to as 'The Social Services Agency'.

For Mental Health this responsibility is delegated to the appropriate Kent and Medway NHS and Social Care (Partnership) Trust. For all other adult service users the responsibility rests with the appropriate team within Kent County Council Social Services or Medway Council Children and Adults Directorate. This will apply to abuse that is alleged to have occurred within any NHS service setting. The sole exception relates to abuse alleged to have occurred in services provided by Acute Hospital Trusts, where the Acute Trusts have the responsibility to co-ordinate the response to the concerns raised.

This document should be read in conjunction with the following publications. Serious Untoward Incident Reporting Procedures, Care Programme Approach/Risk Assessment Procedures, the Memorandum of Understanding 'Investigating patient safety incidents (unexpected death or serious untoward harm), and the model for investigation that is contained within the Department of Health document 'Building a Safer NHS'. Issues of adult protection must be considered and these other processes may assist in addressing the concerns. The work must be evidenced and recorded through the multi agency alert and monitoring procedures.

The following policy, protocols and guidance are applicable to all adult client groups. The employees of all statutory organisations including housing providers and Private and Voluntary Agencies are expected to recognise the policy and to work in accordance with the protocols. There should be a named person or post in each agency/service who has responsibility for adult protection.
The following agencies are represented on the Safeguarding Vulnerable Adults Executive Board and are responsible for ensuring that all agencies and services in Kent and Medway are committed to working within the policy, protocols and the guidance which support practice:

Kent County Council  
Medway Council  
Kent Police  
Health Trusts in Kent and Medway  
NHS England  
Clinical Commissioning Groups  
Kent Probation  
District Councils in Kent  
South East Coast Ambulance Trust  
Kent and Medway Care Alliance  
Kent Care Homes Association  
Kent Community Care Association  
Kent Fire and Rescue Service  
Kent Prison Service

The following have contributed to the development of the policy, protocols and guidance:

- Abbeyfield Kent Society  
- Age Concern in Kent and Medway  
- Carers VOICE  
- Crown Prosecution Service  
- Health Trusts in Kent and Medway  
- Invicta Lifeline  
- Kent and Medway Adult Protection Service Users Forum  
- Kent Care Homes Association  
- Kent Community Care Association  
- Kent County Council Social Services  
- Kent Police  
- Medway Children and Adults Directorate  
- MENCAP (KENT)  
- Tonbridge and Malling Housing Association  
- Victim Support  
- NHS Counter Fraud & Security Management Service (CFSMS)  
- Kent Fire and Rescue Service

The Department of Work and Pensions and the Care Quality Commission have been involved and consulted during the development of these documents.

Amended July 2013
Consultation and review

The multi-agency adult protection policy, protocols and guidance will be reviewed every six months and everyone is invited to comment on them at any stage. Necessary updates will be made and dated six monthly and published on the Kent and Medway Council’s website’s on www.kent.gov.uk and www.medway.gov.uk. If changes are necessary they will normally be published on 31st January and 31st July each year. People may forward their views in writing or by telephone to the following addresses:

**The Safeguarding Adults Policy and Standards Manager** Kent County Council, Social Services Headquarters 3rd Floor, Brenchley House, 123/135 Week Street, Maidstone, Kent ME14 1RF

**Principal Officer for Safeguarding Adults** Medway Council, Children and Adults Directorate, Level 4, Gun Wharf, Dock Road, Chatham, Kent. ME4 4TR

Complaints

If you have reason to believe that concerns about an adult protection issue have not been appropriately addressed you may make a formal complaint by contacting the Adult Social Services Customer Care Department at Kent County Council or to Social Care Complaints Manager, Medway Council at the above addresses.

**Please note** that depending on the specific nature and circumstances of the adult protection case the complaint will be logged and acknowledged. It may not however be appropriate for the complaint to be investigated until the adult protection case has been concluded, at which time the customer care department will contact you.

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Adult Protection

Policy
1 Why Do We Need a Multi-Agency Adult Protection Policy?

To enhance the quality of life of vulnerable adults
To improve the health of vulnerable adults
To promote the welfare of vulnerable adults
To secure the safety of vulnerable adults

How will the multi-agency policy achieve its aims?

By improving the identification of adult protection issues
By improving organisations’ response to adult protection issues
By seeking to prevent vulnerable adults from being abused
By promoting the adult protection policy
By developing training to address all adult protection
By monitoring the adult protection policy and protocols
By providing information to assist in the prevention of abuse
2 Policy

Principles and values

2.1 It is every adult's right to live free from abuse in accordance with the principles of respect, dignity, autonomy, privacy and equity.

2.2 Priority should be given to the prevention of abuse by raising the awareness of adult protection issues and by fostering a culture of good practice through support and care provision, commissioning and contracting.

2.3 Vulnerable adults who are susceptible or subjected to abuse or mistreatment will receive the highest priority for assessment and support services. All agencies will respond to adult protection concerns with prompt, timely and appropriate action in line with agreed protocols.

2.4 The policy and protocols are applicable to all adult client groups whether living in a domestic setting, care home, social services or health setting or any community setting.

2.5 The partners to this document expect their employees and their contracted agents, whether purchasers or providers, to conform to these policy principles and protocols for adult protection.

2.6 Protection of vulnerable adults is a multi-agency responsibility and this policy and protocols have been produced on a multi-agency basis to promote agencies to actively work together to address the abuse of vulnerable adults.

2.7 This document acknowledges the principles of intervention based on the concept of empowerment and participation of the vulnerable individual or their representative if this is appropriate.

2.8 The adult protection policy and protocols should constitute an integral part of the philosophy and working practices of all agencies involved with vulnerable adults and should not be seen in isolation.

2.9 Adult protection policy and protocols aim to integrate strategies relevant to issues of adult protection/abuse contained in current legislation.

2.10 It is the responsibility of all agencies to take steps to ensure that vulnerable adults are discharged from their care to a safe and appropriate setting.

2.11 The need to provide support for the carers will be taken into account when planning services for vulnerable adults and a carer's assessment should be offered.

2.12 The policy, protocols and guidance are based upon a commitment to equal opportunities and practice in respect of race, culture, religion, disability, gender, age or sexual orientation.

2.13 The partners involved in developing this document are committed to supporting multi-agency training, education and information for everyone concerned, to create a climate in which adult abuse is regarded as unacceptable.
3 What is Adult Abuse and to Whom Does it Apply?

3.1 What do we mean by abuse?

“Abuse is a violation of an individual's human and civil rights by any other person or persons”

Abuse of a vulnerable adult may consist of a single act or repeated acts. It may occur as a result of a failure to undertake action or appropriate care tasks. It may be an act of neglect or an omission to act, or it may occur where a vulnerable person is persuaded to enter into a financial or sexual transaction to which they have not, or cannot, consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the individual.

Concerns about abuse may be raised and reported to the social services agency as a result of a single incident or repeated incidents of abuse. However for some clients the issues of abuse relate to neglect and poor standards of care. They are ongoing and if ignored may result in a severe deterioration in both physical and mental health and even death.

Anyone who has concerns about poor care standards and neglect in a care setting may raise these within the service, with the regulatory body and/or with the social services agency.

Where these concerns relate to a vulnerable adult living in their own home, with family or with informal carers they should be reported to the social services agency. These reports should be addressed through the adult protection process and a risk assessment should be undertaken to determine an appropriate response to reduce or remove the risk.

3.2 Who is included under the heading 'vulnerable adult’?

An Adult (a person aged 18 or over) who 'is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. (Definition from 'No Secrets' March 2000 Department of Health)

This could include people with learning disabilities, mental health problems, older people and people with a physical disability or impairment. It is important to include people whose condition and subsequent vulnerability fluctuates. This may include individuals who may be vulnerable as a consequence of their role as a carer or whilst a hospital inpatient in relation to any of the above. It may also include victims of domestic abuse, hate crime and anti social abuse behaviour. The persons' need for additional support to protect themselves may be increased when complicated by additional factors, such as, physical frailty or chronic illness, sensory impairment, challenging behaviour, drug or alcohol problems, social or emotional problems, poverty or homelessness.

Many vulnerable adults may not realise that they are being abused. For instance an elderly person, accepting that they are dependent on their family, may feel that they must tolerate losing control of their finances or their physical environment. They may be reluctant to assert themselves for fear of upsetting their carers or making the situation worse.
It is important to consider the meaning of ‘Significant Harm’. The Law Commission, in its consultation document ‘Who Decides,’ issued in Dec 1997 suggested that; ‘harm’ should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also ‘the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development’.

3.2.1 Vulnerable adult to vulnerable adult abuse

It is important to understand that a vulnerable adult may also be abused by another vulnerable adult. In some settings this behaviour may not have been considered to be abuse.

Research has shown that where this kind of abuse is ignored or not addressed appropriately, the victims may suffer mental health problems, low self esteem and may also become perpetrators of abuse against others.

It is therefore necessary to address what may have become culturally acceptable behaviour; this could be an acceptance that vulnerable adults abuse each other, or come from settings where behaviour and/or attitudes, which we now agree to be abusive, were accepted and condoned by staff and/or vulnerable adults.

When vulnerable adults are subject to sections of the Mental Health Act 1983 or to the criminal justice system, they are still entitled to be both protected from abuse and prevented from abusing other vulnerable adults.

For more information see: Additional Guidance to Support Agencies and Services to Respond to Abuse of Vulnerable Adults by other Vulnerable Adults document on the Kent.gov website

3.3 Criminal offences

Some instances of abuse will constitute a criminal offence. This may lead to criminal proceedings and appropriate intervention must take this into account. Vulnerable adults are entitled to the protection of the law in the same way as any other members of the public.

Alleged criminal offences differ from all other non-criminal forms of abuse in that the responsibility for initiating investigative action rests with the Police. Decisions regarding prosecution are the responsibility of the Crown Prosecution Service. Therefore whenever complaints about alleged abuse suggest that a criminal offence may have been committed it is imperative that contact is made with the police as a matter of urgency. Criminal investigation by the police takes priority over all other lines of enquiry. Ensuring the safety of victims however must be assured.

More detailed guidance regarding criminal offences and working with the police can be found in guidance section 15
Types of Abuse

The following categories of abuse are not mutually exclusive and a vulnerable adult may be subjected to more than one type of abuse at the same time, whatever the setting.

It is important to recognise that some vulnerable adults may reveal abuse themselves by talking about or drawing attention to physical signs or displaying certain actions/gestures. This may be their only means of communication. It is important for carers to be alert to these signs and to consider what they might mean.

Further information about indicators of abuse under each of these main headings can be found in the guidance section 3.

4.1 Physical abuse

- Hitting, slapping, scratching.
- Pushing or rough handling.
- Assault and battery.
- Restraining without justifiable reasons.
- Inappropriate and unauthorised use of medication.
- Using medication as a chemical form of restraint.
- Inappropriate sanctions including deprivation of food, clothing, warmth and health care needs.

4.2 Sexual abuse

- Sexual activity which an adult client cannot or has not consented to or has been pressured into.
- Sexual activity which takes place when the adult client is unaware of the consequences or risks involved.
- Rape or attempted rape.
- Sexual assault and harassment.
- Non contact abuse e.g. voyeurism, pornography.

4.3 Psychological abuse

- Emotional abuse.
- Verbal abuse.
- Humiliation and ridicule.
- Threats of punishment, abandonment, intimidation or exclusion from services.
- Isolation or withdrawal from services or supportive networks.
- Deliberate denial of religious or cultural needs.
- Failure to provide access to appropriate social skills and educational development training.

4.4 Financial abuse

- Misuse or theft of money.
- Fraud and/or extortion of material assets.
- Misuse or misappropriation of property, possessions or benefits.
- Exploitation, pressure in connection with wills, property or inheritance.
4.5 Neglect and acts of omission

- Ignoring medical or physical care needs.
- Failure to access care or equipment for functional independence.
- Failure to give prescribed medication.
- Failure to provide access to appropriate health, social care or educational services.
- Neglect of accommodation, heating, lighting etc.
- Failure to give privacy and dignity.
- Professional neglect.

4.6 Discriminatory abuse

- Discrimination demonstrated on any grounds including sex, race, colour, language,
culture, religion, politics or sexual orientation.
- Discrimination that is based on a person’s disability or age.
- Harassment and slurs which are degrading.
- Hate crime. (see policy section 4.13)

4.7 Institutional abuse

Institutional abuse although not a separate category of abuse in itself, requires specific mention simply to highlight that adults placed in any kind of care home or day care establishment are potentially vulnerable to abuse and exploitation. This can be especially so when care standards and practices fall below an acceptable level as detailed in the contract specification.

4.8 Multiple forms of abuse

Multiple forms of abuse may occur in an ongoing relationship or an abusive service setting to one person, or to more than one person at a time, making it important to look beyond single incidents or breaches in standards, to underlying dynamics and patterns of harm. Any or all of these types of abuse may be perpetrated as the result of deliberate intent and targeting of vulnerable people, negligence or ignorance.

4.9 Domestic abuse

Home Office Definition endorsed by the Association of Chief Police Officers: March 2013

The new definition will be effective through England and Wales from March 2013 and is inclusive for male and females. It is:-

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

Coercive behaviour is: an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
Domestic abuse is not a specific criminal offence. The term is used to describe a range of incidents occurring in particular circumstances where the victims can be of any gender and from any ethnic group as can the perpetrator.

Kent Police will respond to all victims of domestic abuse so they can receive the appropriate quality of service according to their individual needs. All allegations will be properly investigated and the perpetrators held accountable through the criminal justice system.

A separate Domestic Abuse Protocol for Kent and Medway is in place between Police, Social Services and Health.

Incidents reported by the police through the domestic abuse protocols will be addressed under the adult protection processes if it is considered that a vulnerable adult may be at risk of abuse.

See Joint Police, Social Services and Health Protocol for dealing with cases of domestic abuse where vulnerable adults are involved. This joint protocol which deals with risk assessment and referral to Multi agency risk assessment conference (MARAC) should work in parallel with safeguarding adults’ procedures. They should not be separate.

From 13th April 2011 there has been a statutory requirement to consider carrying out a domestic homicide review in all relevant cases. Kent and Medway have developed separate Domestic Homicide Review Protocols which support local practice. These have been written in line with the Home Office Guidance.

4.10 Self neglect or self injurious behaviour

This should be considered as a separate issue and should necessitate assessment by social and/or health care professionals. This assessment should be carried out within the guidance contained within the Mental Capacity Act 2005.

For more information please see Social Care Institute for Excellence Self Neglect Report - 46

4.11 Restraint (formally referred to as Physical Intervention)

It is illegal and unprofessional to use any form of physical, mechanical, emotional or any other form of restraint as a means of punishment. This could also include chemical restraint i.e. the inappropriate use of medication to sedate or control behaviour. Every employee has a professional and moral duty to protect all vulnerable adults and promote their welfare and safety.

Restraint may only be considered in those situations where there is a clear or perceived risk of an adult injuring him/herself or others, or seriously damaging property. Physical restraint is defined as ‘the positive application of force with the intention of overpowering the adult in order to protect him/her from harming themselves, others or seriously damaging property’ (On Restraint with Children and Learning Disabilities, Professor C Lyons HMSO). Any use of physical force may constitute an assault and therefore must be applied only as a last resort.

Section 6(4) of the Mental Capacity Act (MCA) 2005 states that someone is using restraint if they:

- use force – or threaten to use force – to make someone do something they are resisting, or
- restrict a person’s freedom of movement, whether they are resisting or not.

Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
the amount or type of restraint used and the amount of time it lasts must be a proportionate `response to the likelihood and seriousness of harm.

If any form of restraint is carried out in an individual situation, it must be evident that without such action, injury would occur to the vulnerable adult or others or serious property damage may result. Before considering any type of restraint, all other possible alternatives must be explored in order to manage the behaviour and only the least restrictive and least detrimental alternative should be employed. Any restraint should be commensurate with the risk involved and should only be used as a short-term measure. Care plans developed with input from service user, family, health and social care professionals should clearly identify when and how any agreed restraint method can be used. This must be monitored closely by the service to ensure that agreed procedures are effective and not abusive, counter-productive or unlawful.

The final decision to restrain an individual rests with the responsible manager and it is essential that any instances of restraint are clearly recorded. The information must specify the following:

- Reason for restraint
- Nature of risk leading to restraint
- Method of restraint
- Who was involved in the restraint
- Date, time and duration of restraint
- Any injuries noted as a result of the restraint.

It is essential that the next of kin and/or family members are kept informed of any such actions.

The responsible manager should immediately confirm the actions taken in writing to the care/case manager and where appropriate seek advice from them or health care professionals regarding future management of client's behaviour if the agreed procedures do not appear to be effective.

If good principles of physical intervention are not in place and applied appropriately any form of physical intervention may be considered as abuse.

All health in-patient services, private hospitals, statutory private and voluntary residential services that manage service users' violence and aggressive behaviour may, as a result of such behaviour, wish to incorporate a physical intervention strategy into service users' care plans. All such services must have in place the following:

- A managing violence and aggression policy
- Staff training programme, which validates staff competence to carry out procedures
- An agreed methodology of recording all such incidents.

It is considered good practice that all the above services should carry out an annual audit on their use of physical interventions so that monitoring organisations can review its usage.

4.12 Deprivation of Liberty Safeguards (DOLS)

See also Legal Section 2 in Guidance

DOLS apply to people who:
- are aged 18 and over
- suffer from a mental disorder
- lack the capacity to give consent to the arrangements made for their care or treatment in a care home or hospital, under public or private arrangements
- and for whom a deprivation of liberty is considered, after an independent assessment, to be a necessary and proportionate response in their best interests to protect them from harm
- and detention under the Mental Health Act 1983 is not appropriate for the person at that time
What should I consider when working with people who may be affected by DOLS?

Keep the five principles of the Mental Capacity Act 2005 (MCA) in mind at all times. If a person is at risk of deprivation of liberty because they are subject to frequent, cumulative and ongoing restriction or restraint, consideration should always be given to less restrictive alternatives. If this cannot be achieved, then you must apply for an authorisation under DOLS (see www.kent.gov.uk/mentalcapacityact).

Restraint
- the use or threat of force to help carry out an act that the person resists; may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm

Restriction of liberty
- an act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty

Deprivation of liberty
- used in the European Convention on Human Rights about circumstances when a person’s freedom is taken away

A person may only be deprived of their liberty:
- in their own best interests to protect them from harm
- if it is a proportionate response to the likelihood and seriousness of the harm
- if there is no less restrictive alternative

The difference between deprivation of liberty and restriction upon liberty is one of degree or intensity. It may therefore be helpful to envisage a scale, which moves from ‘restraint’ or ‘restriction’ to ‘deprivation of liberty’. Where an individual is on the scale will depend on the concrete circumstances of the individual and may change over time.

The European Court of Human Rights and UK courts have determined a number of cases about deprivation of liberty. Their judgments indicate that the following factors can be relevant to identifying whether steps taken involve more than restraint and amount to a deprivation of liberty. It is important to remember that this list is not exclusive; other factors may arise in future in particular cases.

- Restraint is used, including sedation, to admit a person to an institution where that person is resisting admission.
- Staff exercise complete and effective control over the care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment, contacts and residence.
- A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate.
- A request by carers for a person to be discharged to their care is refused.
- The person is unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control.

How can deprivation of liberty be identified?

In determining whether deprivation of liberty has occurred, or is likely to occur, decision-makers need to consider all the facts in a particular case. In general, the decision-maker should always consider the following:

- All the circumstances of each and every case.
- What measures are being taken in relation to the individual? When are they required? For what period do they endure? What are the effects of any restraints or restrictions on the individual? Why are they necessary? What aim do they seek to meet?
What are the views of the relevant person, their family or carers? Do any of them object to the measures?

How are any restraints or restrictions implemented? Do any of the constraints on the individual’s personal freedom go beyond ‘restraint’ or ‘restriction’ to the extent that they constitute a deprivation of liberty?

Are there any less restrictive options for delivering care or treatment that avoid deprivation of liberty altogether?

Does the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty, even if individually they would not?

What practical steps can be taken to reduce the risk of deprivation of liberty occurring?

Staff should minimise the restrictions imposed and ensure that decisions are taken with the involvement of the relevant person and their family, friends and carers.

- Make sure that all decisions are taken and reviewed in a structured way, and reasons for decisions recorded.
- Follow established good practice for care planning.
- Make a proper assessment of whether the person lacks capacity to decide whether or not to accept the care or treatment proposed, in line with the principles of the Mental Capacity Act.
- Before admitting a person to hospital or residential care in circumstances that may amount to a deprivation of liberty, consider whether the person's needs could be met in a less restrictive way.
- Any restrictions placed on the person while in hospital or in a care home must be kept to the minimum necessary, and should be in place for the shortest possible period.
- Take proper steps to help the relevant person retain contact with family, friends and carers. Where local advocacy services are available, their involvement should be encouraged to support the person and their family, friends and carers.
- Review the care plan on an ongoing basis. It may well be helpful to include an independent element, possibly via an advocacy service, in the review.

The Link between DOLS and Safeguarding Adults Processes

The majority of applications which result in an authorisation not being granted is due to the Best Interests Assessor (BIA)’s conclusion that deprivation of liberty is not occurring. In cases where authorisation is not granted because the best interests assessment fails for other reasons, e.g. the deprivation is not considered to be in the relevant person’s best interests, or mental capacity assessment fails because the person is assessed to have capacity, then it becomes a situation of unlawful deprivation of liberty and potential safeguarding concern.

When this happens, the relevant Supervisory Body (SB) signatory is immediately alerted by the DOLS office so that they are aware of the seriousness of the unlawful situation. The DOLS office will also immediately inform the Managing Authority that DOLS authorisation is not granted and the relevant person is now being unlawfully deprived of their liberty. The responsibility then falls on the individual SB to contact the MA and agree to take things forward as appropriate, so that action is taken to end the unlawful deprivation of liberty as swiftly as possible and safeguarding alerts raised where appropriate.
4.13 Hate Crime

What constitutes hate crime?
Hate crime is any offence against a person or property that is motivated by the offender’s hatred of people who are seen as being different. You can be a victim of hate crime because of your race, religion, disability, age, sexuality or gender.

Why report hate crime?
You can:
- Help police investigate an incident which may contribute to an arrest and/or prosecution
- Help police to understand patterns of behaviour
- Provide a true picture of what is happening within your community
- Help to prevent these types of crimes happening to yourself in the future or to someone else

Reporting an Incident
You can report any type of hate crime, however small the incident, including criminal damage, assault, verbal abuse and harassment.

Choose from the following methods to report your concerns:
- Call the Kent Hate Crime incident reporting (Racial, Homophobic and Transphobic) line on freephone 0800 138 1624
- Call Kent Police on 01622 690690 or by dialing 101 – there are specially trained officers in your area that you can speak to in confidence
- Visit www.report-it.org.uk – this is the website of True Vision

Disability Hate Crime
True Vision has launched a new reporting form for those targeted as a result of their physical disability, sensory impairment, learning disability or mental health needs. Hate crimes and incidents can be against the person or property.
Disability Hate Crime hurts. By reporting it you can help yourself or another and may help prevent it from happening to someone else.

An easy read version is available in print on request.
Recognising Abuse

'Research to date has found cases of abuse and neglect in all social and economic strata, in rural and urban settings, in all religious groups and in all races' (Shifting Emphasis from Abused to Abuser D G Bennett, May 1990).

It is important to consider the environment and context in which abuse is alleged or suspected because exploitation, deception, misuse of authority, intimidation or coercion may result in the vulnerable adult being incapable of making his or her own decisions.

Initial rejections of help by the vulnerable adult should not always be taken as final. Provision of a safe place for the vulnerable adult, should be considered to enable the vulnerable adult to feel safe to make a free choice about how to proceed.

It is important to recognise adult abuse at an early stage and take effective action within the multi-agency framework to address the issues. For further information about patterns of abuse/abusing and information about predisposing factors that may lead to abuse, please see guidance section 3.
Priority for Referral and Assessment of the Concerns

- **ALL AGENCIES IN KENT AND MEDWAY ARE COMMITTED TO ENSURING THE SAFETY AND CARE OF VULNERABLE ADULTS AND CHILDREN.**

- **EVERY REPORTED CASE MUST BE ASSESSED BY THE SOCIAL SERVICES AGENCY AS A MATTER OF URGENCY TO DETERMINE AN APPROPRIATE COURSE OF ACTION.**

- **THIS ASSESSMENT WILL TAKE PLACE, EITHER DURING TELEPHONE CONSULTATIONS WITH OTHER AGENCIES/PROFESSIONALS OR DURING A FORMAL PLANNING/STRATEGY MEETING.**

- **REMEMBER: EVERY STAFF MEMBER (AND VOLUNTEER) IN ALL AGENCIES AND SERVICES HAS A PROFESSIONAL AND MORAL DUTY TO REPORT ANY WITNESSED OR SUSPECTED ABUSE TO THEIR LINE MANAGER IMMEDIATELY. IF THERE IS SUFFICIENT CAUSE FOR CONCERN, THE LINE MANAGER SHOULD ENSURE THAT THE INFORMATION IS REFERRED IMMEDIATELY TO THE SOCIAL SERVICES AGENCY IN ALL CASES EXCEPT WHERE THE ABUSE IS ALLEGED TO HAVE OCCURRED IN SERVICES PROVIDED BY AN ACUTE HOSPITAL TRUST.**

- **IT IS IMPORTANT TO ENSURE THAT HEALTH AND SOCIAL CARE PROFESSIONALS IN PRACTICE PLACEMENTS RECEIVE SUPPORT FROM COLLEGES AND UNIVERSITIES AND PLACEMENT SUPERVISORS WHEN THEY HAVE CONCERNS ABOUT POSSIBLE ABUSE OR POOR CARE BEING PROVIDED WITHIN THE SERVICE.**

Referral to the social services agency must take place as soon as possible after the abuse has been recognised or disclosed. For other agencies and services the alert/report form AP1 (see guidance section 6) should be completed and directed to the social service agency. For further clarification please see protocol section 4.3). If the local office is closed reports can be directed to the Social Services Out of Hours Team. They will take any emergency protective action considered necessary and pass the alert to the appropriate locality team leader/service manager/mental health manager at the social service local office/mental health trust office for planning action to be taken.

Where abuse is alleged to have occurred within a service provided by an Acute Hospital Trust the issues should be reported to the relevant hospital adult protection lead manager or to the social services agency who will pass the referral of alleged abuse to the hospital adult protection lead manager. Please see protocol section 17 & 17a.

- **THE RESPONSIBILITY FOR THE CO-ORDINATION OF ALL ADULT PROTECTION ISSUES OCCURRING WITHIN SERVICES PROVIDED BY AN ACUTE HOSPITAL TRUST RESTS WITH THE MANAGEMENT OF THE TRUST.** Please see protocol section 17 & 17a.

Adult protection alerts should ideally be completed within 6 months, except in circumstances agreed with a senior manager. Where investigation and assessment has been concluded but significant concerns remain, a post abuse care plan should identify monitoring and review arrangements.
6.1 What is the function of the initial assessment/planning process?

Adult protection is a complex and multi-layered process. Wherever abuse is reported it is essential to undertake an evaluation of the information received and recorded on the adult protection alert/referral form. This evaluation process must be recorded on the alert/referral form. This process will take into account a range of factors that will determine how the concerns may be addressed. These include:

- The reliability/credibility of the information received
- The need for any emergency or other protective action
- The possibility that the alleged abuse is a criminal offence
- The impact of the alleged abuse on the vulnerable adult(s)
- The capacity of the vulnerable adult(s) for self determination
- The vulnerability of the individual(s)
- The extent of the abuse to this or other vulnerable adults or children
- The length of time it has been occurring
- The risk of repeated or escalating acts involving this or other vulnerable adults or children
- Any information about the alleged perpetrator(s)
- The need for further assessment and or investigation.

See guidance section 29

7 Safeguarding Children

Under the Children Act 2004 everyone has responsibility to carry out their normal functions having regard to the need to safeguard and promote the welfare of children and young people and for ensuring that they are protected from harm.

This includes work carried out in relation to assessments and reviews of vulnerable adults and carers, provision of services and in relation to safeguarding vulnerable adults’ processes.

7.1 Allegation management

In all adult protection cases where an alleged or confirmed perpetrator of abuse is a staff member or volunteer working with vulnerable adults in any setting, an assessment must be carried out through the adult protection process to determine if this perpetrator poses a risk to identified children or young people.

If this assessment indicates that there is a possible risk to children or young people, a referral must be made to the local Children’s Social Services team. They will be responsible for addressing any reported concerns of harm or possible harm to children as a result of the referral from adult social services.
Adult Protection

Protocols
What Do These Protocols Cover?

These protocols intend to lead you through the process of reporting adult protection concerns; sharing information during the evaluation of initial reports, planning, investigation/assessment and decision making phases and then contributing as necessary to a case conference in which issues of ongoing protection, support and redress will be explored.

These protocols should be read in conjunction with the Untoward Incident Reporting Procedures, Care Programme Approach/Risk Assessment Procedures and the Memorandum of Understanding--Investigating Patient Safety Incidents (unexpected death or serious untoward harm) and the model for investigation that is contained within the Department of Health document 'Building a Safer NHS'. Issues of adult protection must be considered and these other processes may assist in addressing the concerns.

The work must be evidenced and recorded through the multi agency alert and monitoring procedures.
Who is Responsible for Ensuring Adult Protection Concerns are Addressed?

Everyone has a responsibility to ensure that concerns about the abuse of vulnerable adults are addressed. The lead responsibility for managing adult protection lies with the Social Services Agency although the government requires other organisations to work in partnership with them. Every reported incident of abuse, or suspected abuse, must be taken seriously and addressed with appropriate urgency and an adult protection alert/referral form must be completed.

1.1 Possible responses

There may be a number of possible responses when an adult protection concern is discussed with the social services agency. (See guidance section 35). At any stage in the process from initial consultation/formal referral to case conference, it may be determined that:

- It is not adult abuse or it is discounted following evaluation/assessment or Information received.
- There is evidence of abuse and it appears more appropriate to address the problem in a less formal way e.g. through the provision of support services for a stressed carer.
- It is not adult abuse but a care management assessment is instigated.
- It is abuse but the victim is not a vulnerable adult. Referral to a more appropriate service may be suggested e.g. domestic abuse, housing services, police.
- It appears to be abuse, the alleged victim is a vulnerable adult and the formal adult protection process is followed. (see section 35a)
- The concerns relate to general poor standards of care in a regulated setting and referral to the regulatory authority is more appropriate. The information may also be passed to the contract team.
What do these Protocols Cover?

The adult protection protocols set out a framework with documentation to assist in all stages of the adult protection process.

When there are issues or concerns regarding abuse or suspected abuse of a vulnerable adult, in any setting, these should be passed to the social services agency office closest to the home of the vulnerable adult. They will then ensure that all the relevant information available at this early stage is recorded and acted upon. Contact addresses are included at the end of the guidance section.

Some issues of concern may be very complex, involving one or more vulnerable adults and several agencies. These will require the complete adult protection process to be completed.

Less complex cases may require a less formal approach but one that still ensures that consultation takes place and is recorded and that the vulnerable adult is protected. At any stage in the adult protection process the designated senior officer may make a professional decision that the issues of abuse or possible abuse have been resolved or addressed. The senior manager in the social services agency will be responsible for signing off the case as completed. Their decision will be communicated to those people who have a ‘need to know’ the outcome of the referral. Otherwise adult protection cases will progress through all the following stages:

- Alerting (recognising)
- Consultation (optional)
- Referring (passing concerns to the social services agency)
- Planning action
- Investigating/Assessing - Impact of abuse on vulnerable adult(s)
- Case Conferencing
- Post abuse care planning
- Monitoring/Reviewing

This document seeks to help you to appreciate the issues that occur at each of these stages.
Lead Responsibility

A Designated Senior Officer (DSO) is responsible for the management of individual adult protection cases within the social services agency. The designated senior officer may be:

- Locality, Head of Service, Safeguarding adults co-ordinator, Team manager or Senior Practitioner in Kent Social Services,
- Service Manager or Team Manager or Senior Practitioner in Medway Adults and Children’s Directorate
- Associate Director, Service Manager or Team Manager, in a Mental Health Trust.
- Hospital Adult Protection Lead Manager (Cases occurring in a service managed by an Acute Hospital Trust)

However the ultimate responsibility for decision making in adult protection cases remains with the Locality, Head of Service for Kent, the Assistant Director for Adult Social Care for Medway and the Head of Safeguarding for the Kent and Medway Partnership Trust.

The designated senior officer may delegate the task of assessment/investigation to an experienced practitioner who has received an appropriate level of training and has relevant experience and knowledge, from whichever agency they work and they will then report back to the DSO. This practitioner will be referred to as the investigating officer (IO). Where the nominated IO is not a representative of the social services agency, the coordination of the investigation/assessment will be the responsibility of the DSO. The DSO or the social services agencies investigating officer will work with those charged with carrying out aspects of the investigation/assessment to coordinate the work to meet the terms of reference agreed for the investigation/assessment work.

It is important that the practitioner leading the investigation should be independent of the decision making within the safeguarding concerns, although the evidence they provide will support effective decision making.

The designated officer may be a police officer or a representative of the NHS.

While a designated senior officer takes overall managerial responsibility for the adult protection process for each case, the investigating officer is responsible for specific issues. As identified in protocols section 13.2 and guidance section 24.
Referral

4.1 Who should report concerns about adult abuse?

Anyone may report concerns of abuse or suspected abuse directly to the social services agency. These reports may be made by phone. Service providers should also use form AP1 in guidance section 6.

Many organisations however will have internal procedures to ensure that concerns are picked up at an early stage. These should set out when situations should be passed on outside the boundaries of their own agencies.

In any regulated service i.e. care home or domiciliary care service; there is a legal requirement to report concerns about the welfare of a vulnerable adult to the relevant regulatory body. These services are required under the Care Standards Act 2000, to give notice to the regulatory body without delay, of any death, illness or other serious events occurring within the service. This includes:

- Any serious injury to any person receiving services from the organisation.
- Any event which affects the well-being or safety of any service user.
- Any allegation of abuse of a vulnerable adult by the registered person or any person who works for the organisation.

Contact details for regulatory bodies are included in the guidance section 37.

Internal procedures will usually ask individual staff who have concerns to report these via a senior manager. All staff should also be made aware that they can approach the regulatory bodies, the social services agency or the police independently to discuss any worries they have about abusive acts or services and that they should do so if:

- They have concerns that their manager or proprietor may be implicated.
- They have grounds for thinking that the manager or proprietor will not take the matter seriously and/or act appropriately to protect service users.
- They fear intimidation and/or have immediate concerns for their own or for a service user's safety.

Whistleblowers (guidance section 13) should know how to access support and to protect their own interests. Even if they decide that they wish to make an anonymous report the information they provide will be taken into account and treated seriously.

All requests for anonymity by the referrer will be fully respected. It cannot however be guaranteed, especially if the referrer's information becomes an essential element in any subsequent legal proceedings. In addition The Data Protection Act 1998 removes the blanket confidentiality of third party information.
4.2 Acting in an emergency

All staff in all agencies should be authorised to call the police and/or ambulance service without referring to a senior manager if this would cause delay, in situations where there is immediate risk of harm or need for treatment. Not to do so might later be construed as negligent and as a failure of their duty of care. Staff in regulated settings or agencies and/or in provider units should be made aware that they need not hesitate when calling emergency services on behalf of vulnerable adults and that, unless this were malicious, they should not be subject to sanctions or to disciplinary action. This is because it is the vulnerable adult’s right as a citizen to receive immediate help.

4.3 Who has responsibility to respond?

In any potential adult protection situation within the boundaries of Kent County Council or Medway Council it is normally the responsibility of the particular locality of the Social Services Agency in which the vulnerable adult is resident, to manage the process of planning action, investigation and case conferencing. It is however, the responsibility of the locality/authority who made and/or fund the placement to engage with the adult protection process and carry out any assessment of their clients needs in relation to the allegations made. They should also respond appropriately to any recommendations made as a result of the adult protection process.

If the abuse occurs while the vulnerable adult is on holiday, in respite care or staying with their family in another locality or authority area, it will be appropriate for the temporary host authority/locality to take the lead in co-ordinating the response to the allegations. This is because:

- There are possible implications for the safety and welfare of other service users.
- The police in the host locality/authority are taking the lead in the investigation of an offence.

Effective liaison and collaboration between localities/authorities is essential to ensure that lead responsibility is established where a decision needs to be made.

Hospital care management teams should support adult protection processes when the vulnerable adult is hospitalised

4.4 Referral process

Contact should be made with the appropriate office of the social services agency in line with section 4.3 above. Referrals may be made by telephone and backed up in writing where possible or made in writing in the first instance.

You will need to provide as much information as you can about the extent and nature of the alleged abuse and the context in which you believe that it has occurred. In order for it to be addressed under the adult protection process, concerns will need to relate to an identifiable individual(s).

More general issues relating to standards of care provided by a regulated service should be reported to the regulatory authority.

If you are not clear if the issues of concern should be addressed through the adult protection protocols, a formal consultation process is available to you as described in the next section.
## 4.5 Pre-referral consultation process

If you are uncertain whether or not to refer a matter to the social services agency, a formal pre-referral consultation process is available, to assist in deciding whether an adult protection alert is necessary. This consultation may be anonymous with regard to the identity of the caller and any other people involved. For Kent phone 03000 41 61 61, for Medway phone 01634 334466. State that you are asking to consult about an adult protection concern.

If it becomes clear during the consultation with the social service agency, that an identifiable vulnerable adult(s) have been abused or are at significant risk of abuse, the social services agency has a duty of care to follow up this information by raising an adult protection alert(s).

The qualified member of staff receiving the information will assist you to make a decision by reference to the factors outlined in protocol section 4.7.

Information about the legislative framework within which adult protection operates is available in guidance section 2.

It is essential that at the end of this process everyone is clear whether an adult protection referral is being made, or if the consultee decides not to make a referral at this time.

### 4.5.1 Recording outcomes of pre-referral consultation

The information provided to the social services agency will be recorded in the agency’s duty recording system together with a note of any advice given. If necessary an adult protection referral or a referral for a community care assessment will be completed.

Staff from other organisations must ensure that accurate records are made of the identified concerns and of all consultations made in the process of deciding on appropriate action. The record must include details of the people consulted and all decisions and all actions taken.

## 4.6 How will social services respond to a referral?

The qualified staff member from the social services agency receiving the information will need to determine from the information given whether the concerns raised constitute adult abuse and if the alleged victim is a vulnerable adult. If the referral relates to someone vulnerable to abuse because of their role as a carer, the referral must be raised in the name of that carer.

Staff will consider the information in the context of the situation that has led to the referral being made or concerns being expressed. They will assess the seriousness and the extent of the abuse, which may not always be clear when anxiety is first expressed. They will approach reports of incidents or allegations with an open mind. Some people might need referral to a more suitable service e.g. police, victim support, domestic abuse services or a refuge. Others might need the full support of the adult protection process to allow them to deal with their situation and return safely to their desired lifestyle. See guidance sections 29 and 35.

In all cases, except where it is immediately clear that the allegations do not constitute adult abuse, an adult protection alert/referral form will be completed. The information as presented will be discussed with the line manager and a preliminary decision taken as to whether any further action is required.

- **Decision not to proceed**

If a decision is made at that point not to proceed in line with the adult protection protocols the referrer will be informed that the case is not to be addressed as adult protection. It may, for example, be more appropriate to refer the matter to another agency such as trading standards or the police. A decision may be taken to offer an assessment under the NHS and Community Care Act 1990. If there is any disagreement with this decision then the case must be referred to a senior manager.
If the issues cannot be resolved then referral may be made to the chair or deputy chair of the Safeguarding Vulnerable Adult Board for Kent and Medway. The complaints procedure may be used by anyone outside social services.

- Decision to proceed

This may include emergency protective action. Initial enquiries will be undertaken. A full record will be made of actions taken and information gathered. The line manager will discuss with the senior manager who should take on the role of designated senior officer for the case. (See protocol section 13.1)

4.7 The factors considered in deciding if concerns constitute adult abuse

In all cases the trained and experienced member of staff in the social services agency receiving the information will engage with referrers or consultees to determine whether the concerns raised constitute adult abuse. The following factors need to be taken into consideration:

4.7.1 Whether the situation / Incident as described is appropriate to be addressed under the adult protection protocols see policy sections 3 & 4.

The vulnerable adult’s needs and the appropriateness of interventions should be assessed in light of the situation / incident that has led to contact with any statutory agency or voluntary sector service. These may include: Housing, KCC Community Wardens, Medway Council Community Safety Officers, Environmental health or Trading Standards. Situations or Incidents may include domestic abuse, hate crime or anti-social behaviour. Some people are not normally eligible for an assessment and possible community care services because despite mild disability, age or illness they have previously been able to manage without help. They may for example be accessing Supporting People provision. If they have been subjected to abuse their ability to deal with this and carry on with their normal lives might be reduced. In addition the seriousness or extent of abuse and its effect on the vulnerable adult may not be clear initially.

The social services agency will consider the circumstances which have led to the contact being made and may liaise with a more appropriate service e.g. victim support, domestic abuse services, housing agencies or even a refuge. Kent police offer support to victims of domestic abuse, hate crime and anti social behaviour. There are also specialist officers working in the public protection units who work closely with partner agencies in investigating allegations of abuse of vulnerable people.

It may be that the issue is not adult abuse but the vulnerable adult requires a care management assessment.

4.7.2 Whether the abuse is serious enough to warrant a referral for investigation or assessment

Factors to be considered include:

- The extent of the abusive act(s)
- Whether the abuse was a one-off event or part of a long-standing relationship or pattern
- impact of the abuse on the vulnerable adult
- The impact of the abuse on other vulnerable adults or children
- The intent of the alleged perpetrator
- The illegality of the alleged perpetrator's action(s)
- The risk of the abuse being repeated against this vulnerable adult
- The risk of the abuse being repeated against other vulnerable adults or children
- If the perpetrator is also a vulnerable adult, do they pose an ongoing risk to vulnerable adults or children?

Guidance section 29 may assist in the assessment of seriousness.
4.7.3 What if the vulnerable adult does not want any action taken?

The purpose of adult protection is to secure or return the vulnerable adult's autonomy as far as possible. If the adult has capacity and they are not being unduly pressurised or intimidated they may ask you not to intervene. Their wishes should be respected but this does not remove your responsibility to report any concerns and, where appropriate, for an investigation/assessment to be carried out in any situations where other vulnerable adults or children may be at risk. In order to be sure that the vulnerable adult(s) are deciding for themselves it may be necessary to create a safe place in which to consult the vulnerable adult about their wishes.

4.8 What if the abuse has occurred in a care setting?

The following section outlines what may be appropriately dealt with in-house, what needs to be referred to the social services agency for investigation/assessment and what should immediately be reported to the police. (For incidents occurring in a service provided by an Acute Hospital Trust (See Protocols sections 13.5 and 17)

4.8.1 Referral Internal

There are some adult protection concerns that are raised and acknowledged as such by the service, which may be appropriately dealt with internally provided that the matter has been reported to the regulatory authority. This may include an apparently minor incident involving a member of staff or a disagreement between two service users, where neither is deemed to be vulnerable to the other. This may be verbal, pushing or shoving, but where there is deemed to be an equal power relationship. However, it is important to recognise that any kind of bullying may be considered by the victim as abusive and should therefore be recognised as such.

Following internal discussion and consultation with the commissioning authority and the local social services agency, it may be agreed that a level 1 response is appropriate. (See guidance section 35, Framework for responding to adult protection concerns). The service provider must explain how they intend to investigate/assess the concerns raised in line with their discussions the Level 1 Service Provider Report Form should be emailed to the provider by the DSO. The provider should complete and return the report to the DSO in the agreed timescale.

Following the providers internal investigation/assessment of the case, records must show what actions were taken and by whom, and the outcome, for example, staff disciplinary procedures or staff training, supervision, and development. Specific reference must be made to risk assessment and any additional protective responses necessary for both the victim and the perpetrator. Records should be available to the Regulatory Authority and Commissioning staff.

4.8.2 Referral to Social Services Agency

Where the adult protection concern is of a more serious nature, a formal referral under the Adult Protection Protocols must be made to the social service agency. If it is possible that the abuse might also constitute a criminal offence, the social services agency will contact the police. If the service provider raises the alert they should also inform the regulatory authority and the service users’ funding authority. If the social services agency becomes aware of the adult protection issues before the service provider, they will inform the regulatory authority and the service users’ funding authority.

4.8.3 Referral to Police

If it becomes clear that a criminal offence may have been or has been committed, the police should be contacted immediately.
What Should We Do if One Vulnerable Adult Abuses Another?

Abuse by one vulnerable adult of another within a service setting should be addressed as an adult protection issue. This situation has traditionally been framed in terms of the perpetrator's challenging behaviour and is often not identified as an abusive act. The trigger for reporting concerns is the abusive act itself and not the degree of responsibility or intent of the person carrying out that act.

Many organisations have become accustomed to responding internally to incidents of vulnerable service users who abuse other service users. This has meant that regulatory, contract and commissioning agencies for both the victim and the perpetrator may not have not been informed of the concerns, or been given an opportunity to engage in decision making around the issues. It has also resulted in the multi-agency adult protection protocols being ignored and abuse which may have constituted a criminal offence not being addressed.

Organisations that aim to provide support to service users who have challenging behaviour need to have an understanding of the history and needs of the user to ensure that they are able to both protect them from abuse and prevent them from abusing other vulnerable adults within the service. The organisation must carry out a pre-placement assessment to ensure that they are able to meet the needs of the service user and to develop a care plan and risk assessment to meet those needs.

Zero tolerance. An acceptance by the service of low level abuse/bullying from whatever source will ultimately, if allowed to continue, lead to a culture that is damaging to all vulnerable adults and to staff.

It is important therefore that all instances of abuse are recognised and addressed in the most appropriate manner.

Clearly it is not necessary or desirable for every instance of service users to service user abuse to be reported through formal adult protection processes especially where there is an equal power relationship between the service users. It is however important that the incidents are recognised as abuse and dealt with appropriately. (See protocol 4.7 and 4.8 also see Additional Multi agency protocol)

It is important to ensure that records of what has been witnessed or reported are factual and do not attempt to minimise adult abuse and / or criminal actions. Examples of good recording may include objective information about: what was witnessed? what were you told? who was involved? when and where did this happen?
6 When and How Should We Share Confidential Information?

Whether or not planning a response to an adult protection concern is through informal consultations or a formal meeting you are likely to be sharing information that would normally be considered confidential.

Each agency holds information, which in the normal course of events, is regarded as confidential and will have their own safeguards and procedures for sharing this with other related agencies. Some information will be subject to the Data Protection Act 1998.

Under Section 115 Crime and Disorder Act (1998) a worker has the power (not a duty) to share information if s/he thinks a crime has been or could be committed in the future with personnel within:

- Local Authority
- Health Trusts
- Police
- Probation

This information may be shared at a planning/strategy meeting with the appropriate people as listed above. If representatives of other organisations are present, they may be asked to leave the room whilst this information is being shared. It is the responsibility of the chair of the meeting to make a decision to exclude anyone from any part of the meeting if this facilitates effective communication. It will therefore be important for participants to discuss any concerns they have about sharing information in a multi-disciplinary meeting with the chair, prior to the meeting if at all possible.

6.1 Making decisions about sharing confidential information

Concern about abuse of vulnerable adults provides sufficient grounds to warrant sharing information on a 'need to know' basis and/or 'in the public interest' and unnecessary delays in sharing that information should be avoided. Whenever possible the vulnerable adult must be consulted about information being shared on their behalf. Where they have capacity and they are not being pressured or intimidated their agreement should be sought and their refusal respected. If other vulnerable adults are at risk the 'public interest' principle may over-ride their decision.

The principles that should govern the sharing of information include:

- **Confidentiality must not be confused with secrecy.**

- **Information will only be shared on a 'need to know basis' when it is in the best interests of the service user(s).**

- **Informed consent should be obtained but if it is not possible and other vulnerable adults are at risk, it may be necessary to override the requirement.**

- **It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other vulnerable people may be at risk.**

Statements of confidentiality and equal opportunities should be read out at the beginning of all adult protection meetings. The two statements should be placed at the top of the attendance sheet for meetings and on the first page of the minutes. (See Guidance Section 18)
How Does Initial Information Gathering Take Place?

Once the adult protection alert has been received, the designated senior officer will initiate immediate inquiries to collate what is already known by different individuals, agencies or services about this situation and anything that has a bearing on the assessment of risk.

There are three purposes to be served in these initial inquiries:

1. To pool available information;
2. To evaluate the information;
3. To decide how to proceed and how to co-ordinate input to any assessment/investigation deemed appropriate.

These inquiries may be made over the telephone and recorded. Where the issues are complex and/or more than one agency is involved, a formal planning/strategy meeting of all appropriate agency and service representatives is recommended to ensure that all the issues are fully explored.

These inquiries form the post alert consultation and planning stage. Whether they are carried out by phone or during a formal planning/strategy meeting, they should be initiated as a matter of urgency within 48 hours of the initial allegation being received by the social services agency.

The designated senior officer (DSO) must arrange to:

i. Allocate an appropriately trained and experienced person to become involved in the case and to take any actions that may be required. The allocated person will be referred to as the investigating officer. The DSO will need to consider the communication, language, cultural, religious and gender factors when allocating the case. The DSO will also consider whether any conflict may arise if the client's care/case manager, community or district nurse carries out the investigation/assessment as this may compromises their normal relationship with the client and family/carers. (See protocols section 13.)

The allocated investigating officer(s) may be from the Social Services Agency, NHS, the Police or a service provider (level 1 case).

ii. Check with the other agencies as to whether the vulnerable adult, alleged perpetrator, or setting is known and under what circumstances they have been involved. One or more of the following may be contacted: general practitioner, police (Public Protection Unit), accident & emergency departments, safeguarding nurse or nurse manager, regulatory authority or contract service. Additionally information may be obtained from the probation service and other voluntary or statutory organisations that are providing services to the vulnerable adult or his or her family/carers.
Without embarking on a formal investigation or interviews of vital witnesses the following checks will be carried out by the social services agency to determine if:

a. There is any medical evidence recorded of the abuse itself or the effect it may have had.

b. Any disclosure or witness reports have been completed, signed and dated prior to social services or the police becoming involved.

c. There are any issues related to potential discrimination e.g. cultural, religious, gender or disability issues.

d. There is any documentary evidence such as accident or incident reports or in diaries or log books.

e. The vulnerable adult is aware that they are the subject of an adult protection alert.

f. There are any records referring to consent or capacity to consent.

g. Whether consent has been over-ruled in the interests of this or any other vulnerable adults.

h. The client's wishes have been clearly recorded.

i. Regulatory authorities have been informed, where a care home or domiciliary service is involved.

j. The contracts service has been informed if an organisation with a KCC/Medway contract is involved.

k. The line manager and the human resource department have been contacted where the alleged perpetrator is an employee of the social services agency.

l. Other localities or authorities have been informed of the issues where the vulnerable adult(s) or the alleged perpetrator(s) is funded by them.

m. Family or carers have been informed of the issues, where it is appropriate to do so.
Risk/Protection

Risk assessment and risk management are essential aspects of the adult protection process and need to be considered at every stage. In addition to assessing the risk to individuals identified at the initial referral stage, all participating agencies and services will need to take into account the possible risks to other vulnerable adults or children.

Following discussions with other agencies during the evaluation of information and initial planning stage, the designated senior officer will be responsible for ensuring that the proprietor or registered manager are advised of the adult protection issues unless it is believed that they may be personally implicated in the allegations made.

As a matter of principle, this contact with the proprietor or registered manager of any care service should be undertaken as soon as it is practicable. This is important to enable them to take appropriate steps to protect vulnerable adults or children who may be at risk and to enable them to address their employment responsibilities.

If there is a possibility that a criminal offence has been committed the police should be involved at the earliest possible stage and they will take responsibility for ensuring the preservation of evidence.

In the event of the death of a vulnerable adult where adult protection concerns already exist or are raised around the time of death, the police should be informed of the adult protection issues as a matter of urgency. The police will take responsibility for any investigations and will liaise with the coroner.

The level of risk has to be weighed up in deciding whether to take any emergency action to protect the vulnerable adult(s) or children. There is a risk that such action may alert the alleged perpetrator resulting in evidence being removed or altered.

If the matters involve a regulated care service and it is believed that no criminal offences have been committed, the DSO will need to consider the most appropriate way of securing any documentary evidence.

If emergency action has been taken, a planning process should be co-ordinated, within 48 hours of the alert being received, involving all appropriate agencies, departments and service providers. Where more than one agency is involved, a planning/strategy meeting is recommended to enable full discussion of actions taken and allow for future planning.

If the vulnerable adult lacks or is believed to lack capacity to make decisions with regard to keeping themselves safe consideration should be given to involving relatives or advocates to support the client through the adult protection processes.
8.1 What if the risks involve a care service?

Where there appears to be significant risks to vulnerable adults/service users or potential service users consideration must be given to informing other interested parties of the concerns and possible risk factors. This may include commissioning authorities outside Kent or Medway.

For organisations with contracts with the social services agencies in Kent or Medway this may be achieved by the use of the flag system on the contract database. **Even if the organisation does not have a contract with any agency in Kent or Medway a level of risk should be agreed and commissioning authorities informed of the risk level.** Decisions about risk and communication should be made in consultation with the Head of Service/Service Manager/Assistant Director and the relevant Commissioning Manager. Within Medway Council any decision to suspend placements within a care service will be made within the Council’s specific Embargo Policy.

Any agreement reached must be recorded in the records of the planning process or in the adult protection paperwork at any stage in the adult protection process.

Levels of risk should be classified in the following way:

**Risk level 1**  
An adult protection case is being assessed / investigated but there is currently no evidence that other service users are at risk. This Risk level will only be used when initial abuse concerns are reported in relation to one service user. (For further information contact identified manager).

**Risk level 2**  
An adult protection case is being assessed / investigated and it is possible that other service users may be at risk of significant harm due to abuse, or poor practice. Some or all service users are being assessed in relation to these concerns. (For further information contact the identified manager).

**Risk level 3**  
An adult protection case is being assessed/investigated and there is evidence of significant risk to other service users due to abuse or poor practice. No new placements should be made until the issues have been resolved. (For more details contact the identified manager).

At levels 2 and 3 consideration should be given to advising the families/carers of other residents that an assessment/investigation is being undertaken. If other commissioning authorities have not already been informed they should now be contacted and they will be responsible for informing the families/carers of their clients of the assessment/investigation.

If the service provider has not already been involved within the adult protection process they must be advised by either the designated senior officer or the commissioning manager of any decisions taken during the adult protection process which affect them or their service. (for services within Medway, where risk level 3 has been agreed, communication with the provider will be in line with the Embargo Policy). They will need to consider the appropriateness of admitting any additional residents to the home when an adult protection risk level 2 or 3 has been agreed and an investigation/assessment is in progress. (See Guidance section 23 item 8 bullet point 1)

As the investigation/assessments are completed, actions taken by the service in order to address the concerns will result in ongoing review of the service provision and improvements are likely to result in a lowering of the risk level. This will mean that the risk level will be reduced from 3 to 2 subsequently the risk level will be removed when all of the concerns have been addressed and the service has been reviewed as safe enough.

There are other processes that may be used to address quality in care concerns and/or contract compliance issues which may also use a similar flagging system to indicate levels of concern.

Amended January 2014
8.2 What protective actions may be considered?

If at any stage in the adult protection process it becomes evident that vulnerable adult(s) or children may be exposed to significant risk, immediate protective measures should be considered.

Protective actions might include:

- Consideration by the employer of using their staff disciplinary procedure and adult protection policy for the protection of the vulnerable adult(s) and the alleged perpetrator.
- Moving the vulnerable adult(s) to a place of safety and care (e.g. to an appropriate family member willing and able to provide care, residential home, hospital etc.)
- Informing Children and Families services of the concerns for the child/children.
- Moving the alleged perpetrator to another placement and/or providing additional support;
- Appointment of an independent legal advocate for the vulnerable adult especially where their interests may run counter to those of the various agencies/authorities' legal departments.
The Planning/Strategy Process

The designated senior officer will need to decide if a formal planning/strategy meeting is required. They should take account of the following:

1. That they have sufficient information via consultations with various people/authorities to proceed to an investigation/assessment. If this is the case they will plan how this is to be carried out. They will establish the terms of reference for the investigation/assessment; who will be involved in this work and who will be responsible for each aspect. This must take into account the desired outcome/s of the vulnerable adult. A time scale will be agreed for the completion of the work and the results to be reported back to the DSO. It will be DSO's responsibility to determine the need for a case conference or an alternate way to feedback information about the outcomes to other key participants. These may include the alleged victim and perpetrator, referrer, carers and service providers.

2. That they can move straight to a care/action plan because there is enough information at this stage on which to base a decision. In this case the DSO will ensure that a post abuse care plan is drawn up to safeguard any vulnerable adult(s), in consultation with them and their carers where appropriate. They will also ensure that an appropriate action plan is completed in relation to the person and/or service held responsible. The plans should specify a time for review and any indicators or circumstances that should trigger further action. Appropriate feedback should be given to the referrer at this stage.

3. If the issues do not appear to constitute abuse and other processes are indicated the Locality Head of Service/Service/Area Service manager should sign off the adult protection case and specify what other actions are required. The referrer must be advised of this decision. If they disagree with this decision they should be advised to put their concerns in writing to the manager concerned. This will then be registered as a formal complaint. If a staff member of the social services agency disagrees with the decision taken by the senior manager they may refer their concerns to the chair or the deputy chair of the Kent and Medway Adult Protection Board.

4. They need to hold a formal planning/strategy meeting to explore the issues more widely.

9.1 When is a formal planning/strategy meeting required?

A formal planning/strategy meeting is recommended where any or all of the following factors are present:

a. Several people/authorities have concerns and a meeting will aid decision-making;
b. Several individuals may be at risk;
c. Several agencies are likely to be involved in investigation/assessment;
d. A criminal prosecution is possible;
e. Other legal or regulatory action may be necessary;
f. One or more members of staff have been implicated/suspended;
g. The issue may attract media interest.

In complex cases there may be a need for more than one meeting during the investigative and assessment process. Second and subsequent meetings will be referred to as planning/strategy review meetings.

Amended January 2014
9.2 Formal planning/strategy meeting

This meeting forms part of the formal investigation into the allegations received and should be attended by all relevant professionals/agencies and any other person who has essential information pertaining to the case provided they are not implicated in the allegations. This may include the vulnerable adult(s), a carer, care worker or advocate. Ensure that any action planned, takes account of the desired outcome/s of the vulnerable adult.

Where the allegations involve a staff member from any organisation or agency providing services, a senior representative (i.e. manager or service manager) of that organisation should be invited to the meeting, or to part of the meeting. Exceptions would be where they personally may be implicated in the alleged abuse or where there are good grounds to believe that their presence may impede the sharing of information and/or the investigation. Alternative arrangements to ensure the agency is represented should be made, this may include a representative at Director level or a manager from their Human Resources Department (Personnel).

The chair of the meeting will explain the status of the meeting and outline the reason it has been called. Issues of confidentiality and equal opportunities will be clarified. All present have a responsibility to contribute and will be invited to share any information or concerns they may have in light of the allegation received. If some relevant professionals cannot attend, they may elect to send a report. The meeting will be formally minuted detailing those attending together with relevant apologies. The alert document and any attached papers will be entered into the record of the investigation at this stage. The minutes of the planning/strategy meeting will only be circulated to those participating in or invited to the meeting/part meeting. The chair of the meeting may exercise discretion to send the minutes to other agencies to enable them to fulfil their statutory obligations.

If any attendee disagrees with consensual decisions taken at the meeting they should formally register their concerns at the meeting. The chair of the meeting will refer the matter to their line manager for further consideration as a matter of urgency.

(See planning checklist guidance sections 22 and 25.)
Proceeding to an Investigation

If an investigation is required then the terms of reference for the investigation/assessment must be jointly agreed.

If the alleged perpetrator is a member of staff, human resource advisors should be consulted to ensure that the investigation is compliant with safeguarding arrangements and employment legislation.

They should be informed of the progress of the investigation and where appropriate could be involved in the investigation, provided their involvement does not compromise any criminal investigation.

If a criminal act is suspected then the police investigation will take precedence. It is however, important to ensure that the protection of the vulnerable adult(s) is not unduly delayed by their investigation. Agreement will be required regarding actions to be taken by others while the police investigation is being carried out. Police action may be supported by care/case management, health or regulatory staff but if this is not the case, liaison over the progress of the police investigation should be carried out by the DSO or the investigating officer.

When the police investigation has been completed other investigations may then be required. Where possible, joint interviews with police should be conducted with vulnerable victims and witnesses to avoid delays and duplication of investigative activities.

If the police are not involved then it will be necessary to clarify the terms of reference for the investigation and identify the individuals or departments/agencies to be involved in the investigation/assessment. If an individual vulnerable adult is concerned then it is likely that the social services agency will lead the investigation possibly supported by health professionals.

Two people must be delegated to conduct joint interviews. In criminal cases, one of these will be a police officer; alternatively health, manager of the provider service, contract or human resources staff may be involved. This will ensure accurate recording of any interviews or information received.

Discussions with other professionals will be required to ensure that appropriate support is made available to the vulnerable adult(s) taking into account their cognitive ability, comprehension and communication needs. (See guidance section 24, Investigation/Assessment Checklist.

10.1 How will the investigation be carried out?

An investigation usually has four main strands, they include:

a To establish matters of fact about one or more incident(s) in which abuse is alleged or concerns have been raised.

b To assess the support and protection needs of the vulnerable adult(s) using the safeguarding assessment / risk assessment and protection plan form SA1 as appropriate

c To determine who was responsible and/or culpable and what action should be recommended in relation to them.

d To review the management of the setting/service and any improvements required or sanctions to be recommended.
10.2 Who is responsible for what?

In planning the investigation it should be clear which agency/individual is taking responsibility for each strand. Interviews with vulnerable victims or vulnerable witnesses should be carried out with the support of appropriate social or health care staff regardless of who has the lead responsibility for the investigation. The social services agency will take responsibility for overall co-ordination.

- If the police are not involved the social services agency will take responsibility for a) & b) above, i.e. for finding out what happened and for taking action to protect the person.

- If the police are involved they will be fully responsible for any criminal investigation. When vulnerable adults are to be interviewed it is likely that their interviews will be videoed. The videoed recording(s) are likely to be used in court as the witnesses evidence in chief.

- Where the alleged abuse has taken place in a regulated service and formal statements are required under the Health and Social Care Act 2008. The regulator is responsible for ensuring that any action in relation to regulatory concerns is conducted within the requirements of the Act. (This work may be carried out in parallel with other investigatory activities).

- Where the alleged abuse has taken place in a non-regulated service but one which is contracted, e.g. supporting people, day care or work opportunity service, the social services agency should take the lead but be supported by other appropriate professionals, which may include the manager of the service.

- All interviews will be formally recorded.

Different agencies may take a lead in relation to perpetrators depending on their position and relationship to the client.

- Family members who are carers including young carers may be assessed in terms of their own needs for support as an alternative to sanctions being taken.

- Other service users will warrant a parallel assessment by the social services agency with possible input from health, police, probation, or other agencies.

- Staff members may require co-ordinated input by police, personnel, professional bodies, unions or legal services.

- Employees, service proprietors or managers are more likely to face disciplinary action or actions under the Care Standards Act 2000 or in relation to their professional bodies.

- Members of the public who abuse will probably be subject to police investigation. They may also be subject to action by housing authorities, race equality units etc. As they are outside service or professional frameworks, action through or civil or criminal courts may be considered.

Where any individual has potentially committed a criminal act they may be investigated by the police with a view to prosecution and this may take place in parallel with, and not instead of, these other actions.

The co-ordination role involves sharing information for these different arenas, planning any agreed joint interviews to avoid repeated and distressing rehearsal of the facts, and drawing up a timetable, which acknowledges the different time frames involved in taking these disparate forms of action.

Following the allocation of the case by the designated senior officer, the investigating officer should start the formal investigation process within 48 hours, in conjunction with the other professionals. A timetable should be drawn up indicating the order in which tasks will be undertaken.

Amended July 2012
10.3 A range of investigative actions

These might include any or all of the following:

- Joint visits with other agencies/departments (i.e. police, commissioning staff, regulatory authorities). The designated senior officer will support the investigating officer to plan this action or it will be agreed during the formal planning/strategy meeting;

- Examination of documentary evidence such as files, accident and incident reports, daily logs, accounts, medical records etc.;

- Interviews with witnesses and/or complainants and others who are able to set the scene;

- In cases of suspected sexual or physical abuse, a medical assessment should be made available to the individual. In cases where a person cannot give their consent or where consent is questionable, a responsible medical practitioner will have to make a judgement about whether such an examination (either for medical and/or evidential reasons) is likely to be in the person's best interests.

10.4 Interviewing the vulnerable adult and vulnerable witnesses

The vulnerable adult should not be interviewed alone or in the presence of the alleged perpetrator after their initial disclosure, especially if there is any possibility that a criminal offence may have been committed. In such cases a joint interview would be preferred at which the vulnerable adult may be accompanied by one or more of the following:

a An interpreter, if the person speaks English as their second language, or if they need a British Sign Language interpreter or if they are a person with learning disabilities who uses augmented communication methods such as a word board or Makaton signs. (See protocols for addressing adult protection concerns involving d/Deaf people, in guidance section 9.)

b An independent advocate of their choosing or an independent advocate appointed by the investigator to protect the person's interests.

c A member of their family or close friend, if this is deemed appropriate.
10.5 Compiling a report following investigation

At the end of the investigation a summary of all information gathered should be recorded in the form of a concise report. The investigating officer should compile this report. Those involved may be asked to contribute to one or more sections of the report drawing on their personal or professional knowledge, judgement and/or on specific inquiries carried out as part of the investigation.

The report should cover the following points:

a. Details of the initial alert and of the incident or concern which triggered the referral.
b. Outline of any previous related incidents or allegations.
c. A pen picture of the vulnerable adult and his or her circumstances. If possible record what the vulnerable adult wants to happen as a result of the adult protection process.
d. An assessment of the vulnerable adult's capacity in relation to consent and other legal issues.
e. A sketch of the person's network and social supports.
f. Any issue of discrimination identified.
g. Information about the person alleged responsible for the abuse.
h. A brief account of the investigation process and the input of other agencies.
i. An evaluation of the evidence.
j. An assessment of how serious the abuse has been and whether there is a risk of it escalating or being repeated.
k. Recommendations about future action to support the person and/or manage any ongoing risk.
l. Conclusions about culpability and responsibility for the abuse or harm.
m. Other actions to be taken.
n. Recommendations about when and in what circumstances the case should be revisited.

The completed report should be passed to the designated senior officer for decision making.

The report will be available to inform the case conference. It will be marked ‘Confidential’. If a case conference is not held the information, the outcome and the recommendations for future care planning and monitoring will be shared with people on a ‘need to know’ basis. In cases where the employer is considering disciplinary action or referral to DBS, the designated senior officer will make a copy of the report, or a summary, available to the employer.

The use of the assessment risk and protection planning form is recommended for use to address items c, d, e, f, j, k and n
**Case Conference**

11.1 Will all cases lead to a case conference?

Most investigations, involving agencies in addition to the social services agency, should lead to a formal case conference at which decisions will be taken. A decision not to proceed to a case conference will be made by the DSO and the reasons for not proceeding clearly recorded and shared with key people in other agencies. If anyone has any concerns about a case being brought prematurely to a close they should share their views by phone or in writing to the DSO concerned, who should review his/her decision in discussion with the Senior Manager.

Cases in which a conference is not warranted might include low-level cases that concern only one agency, or in which actions to be taken are straightforward and non-contentious.

Allegations that cannot be substantiated due to insufficient evidence should not be dismissed out of hand careful consideration must be given to ongoing risk management and appropriate record keeping in such cases. A case conference checklist is available in guidance section 25.

Even in those cases where a meeting is not held, a post abuse care plan should be put on record that sets out any provision for enhanced monitoring and specifies arrangements for review of the case. Mechanisms for informing interested parties of the social services agency’s response to the issue of concern will also be set out. Other agencies that have contributed to the investigation will be kept informed about decisions taken during this phase of the response.

The referrer will be informed that the issues have been addressed but may not necessarily be given details of actions taken. A post abuse checklist is available in guidance section 26.

11.2 How should a case conference be conducted?

If a case conference is to be convened, arrangements should be made as soon as possible after receiving the report of the investigation. This should normally be within 21 days of the receipt of the initial allegation and will probably have been agreed as part of the planning process, depending on the remit of the investigation. If, due to unforeseen circumstances, the case conference has to be delayed beyond a period of 21 days this should be agreed by the DSO and reasons for extending the investigation should be clearly recorded. Where it is important that an individual’s General Practitioner attends the case conference, the meeting should be held between 12.00pm and 4.00pm to facilitate this.

11.3 The function of a case conference

The aim of the case conference is to share the outcome of the investigation/assessment(s) and to make recommendations regarding the ongoing care and protection of the vulnerable adult(s), action(s) in relation to the perpetrator(s), in collaboration with other relevant people and agencies.

The case conference should provide a forum for:

- Establishing the facts and putting these on record after full consideration, discussion and joint decision making about the findings of the investigation, and the circumstances surrounding the alleged abuse.

- Agreeing measures to be taken to assure the future protection of vulnerable adult(s) and any ongoing risk management.

- Identifying and supporting sanctions or other interventions to be taken in relation to the perpetrator.

- Specifying actions to be recommended in relation to the service or provider agency.
e Ensuring that full consideration is given to the possibility that other vulnerable adults may be at risk and agreeing action to reduce or eliminate that risk.

f Agreeing appropriate feedback to people, agencies and services on a ‘need to know basis’. This must include the referrer.

g Ensuring that, where ongoing concerns exist which cannot be substantiated by evidence, appropriate monitoring systems are established.

If there is any disagreement with the recommendations and outcomes of the case conference, these should be formally expressed and recorded in the minutes. The appeal procedure would be for the chair of the conference to refer the matter to a senior manager at the earliest opportunity. If agreement is still not reached at this stage then the issues should be referred to the Chair or Deputy Chair of the Safeguarding Vulnerable Adults Board.

11.4 Who participates in case conferences?

It may be necessary to address the different elements of the case in separate sections of the meeting and to vary those attending for different agenda items. Minutes of the conference should only be distributed to the participants or to those invited. If an individual(s) only participated in or were invited to part(s) of the conference, they should only receive minutes relating to that part(s) of the conference.

The following people may be invited to attend all or part of the meeting:

a The vulnerable adult must be invited, however, if they are unable or unwilling to take part, their representative or advocate should be invited to attend appropriate parts of the conference. Every effort should be made to empower the vulnerable adult to play as active a part in the meeting as possible.

b It may not be practical for all vulnerable adults to attend, say for example in the case of a case conference which has a focus on a provider service. Where an individual has been identified as a vulnerable victim, the case manager or investigating officer must inform the vulnerable adult about the meeting and if they are unable or unwilling to take part, their representative, or advocate should be informed. The chair of the meeting must gain agreement about how each vulnerable adult or their representative receives feedback. This must be clearly identified for each vulnerable adult. E.g. meeting at service or local office, letter, relative or residents meeting.

c A close family member, carer, or friend.

d Professionals involved including:

- The Care Manager, Social Worker or CPN;
- The General Practitioner;
- Safeguarding Lead Nurse.

e The alleged perpetrator should only be invited to the case conference in exceptional circumstances and the DSO will take such a decision in discussion with a senior manager. Where this is deemed appropriate the alleged perpetrator would only be invited to those parts of the conference which concern actions to be taken in relation to them. If the alleged perpetrator is another client, then a separate conference may be convened to address their needs.

Depending upon the type of abuse and setting in which it takes place, the following people and agencies may also be invited to attend:

a Police in cases where criminal offences have been identified.

b Regulatory staff if abuse is alleged to have taken place in a care home or other regulated setting or service.
c Representative(s) of relevant NHS Trust(s).

d Contracts manager including a supporting people representative.

e Medical or nursing staff from the accident and emergency department or hospital ward.

f Solicitor from Kent County/Medway Council legal services.

g Representatives from relevant voluntary organisations or provider agencies (not implicated in the abuse).

h HR representative if a member of staff has been implicated.

If the setting or provider agency is deemed responsible for the abuse occurring, an establishment case conference about the service and its management should be held separately after the client focused case conference. The DSO/senior manager should formally advise the management of the service concerned, at least 48 hours prior to the meeting about the issues likely to be raised. Regulatory bodies and commissioning staff should take a more prominent role in this meeting.

11.5 Preparing for the case conference

Where a vulnerable adult or witness is invited to attend all or part of the case conference they should be fully briefed by the chair regarding the arrangements for the meeting and the issues that may well be discussed.

Anyone invited to be part of a case conference should check with the designated senior officer about the role expected of him or her in the conference. They might seek advice about any documents, which may be required during the conference. If this is confidential material from the vulnerable adult's file their permission should be sought, or alternatively authorisation from a manager within your service, about releasing this information in the context of this investigation. If there is a need to summarise a longer report or set of records pick out specific points that have a bearing on the issues arising in this investigation/assessment. For example issues of the vulnerable adult's capacity or ability to protect themselves may be in question. In this case only issues related to this subject need to be addressed. If compiling a special report the aim should be to keep this concise and to the point.

Careful planning is required in instances where institutional abuse is an issue and more than one vulnerable adult or their representative is involved in the meeting. It is important to ensure that confidentiality is maintained and information is shared strictly on a need to know basis.

Read papers in advance of the conference, if they have been made available. Make sure that where these are marked 'highly confidential' appropriate provisions are made for transporting them to, and keeping them after, the conference.

The chair of the case conference should ensure that reports provided to representatives to assist in the decision making are collected at the end of meeting.
11.6 Chairing the case conference

The designated senior officer will usually chair the case conference and formal minutes will be taken. At the meeting the chair will:

a  Ensure appropriate support is provided to the vulnerable adult and/or their representative.
b  Present a brief background of the case and explain the main aims of the conference: this should be followed by a statement of facts and details by the investigating officer in the form of a short report.
c  Facilitate a free and full discussion of the facts in order to jointly establish the status of allegations.
d  Formulate a clearly defined protection plan if appropriate and a mechanism for ongoing support and service arrangements for the vulnerable adult.
e  Facilitate discussion regarding the possible risk to other vulnerable adults and formulate a plan to reduce or remove the risk, in liaison with other agencies.
f  Facilitate the development of a post abuse care plan which documents any actions and assesses ongoing risk and measures to be taken to prevent further abuse.
g  Set out plans for additional services or therapeutic interventions and/or changes in service provision or daily routines.
h  Identify specific indicators that should trigger a review and/or further investigations.
i  Provide a reminder of crucial times/events such as inquests, court cases, release from custody and/or disciplinary hearings that might lead to further precautions becoming necessary.
j  Set out a timetable for review and monitoring arrangements to ensure that the care plan is effectively implemented specifying by whom each task is to be carried out, within what timescale and who is accountable.
k  In a separate section of the meeting, agree what action(s) will be recommended to be taken in relation to the person(s) responsible for the abuse and the setting. If any member of staff is implicated the employer should be invited to attend the relevant part of the conference together with an HR representative if appropriate. If a carer or manager from a regulated setting is implicated, the service provider needs to consider the use of their disciplinary processes and referral to Disclosure and Barring Service or a professional body. If a service user is implicated a separate meeting may be held to consider the issues for them.
l  Summarise the whole discussion and outcome of the conference and arrange a date for reviewing the arrangements made to protect and support the parties involved.
m  Confirm relevant feedback arrangements to appropriate people including the referrer.

In complex cases where the risk of ongoing abuse remains a significant factor, the nature and frequency of review meetings will vary in each case. They should be arranged within six months or earlier if the situation changes and/or the risks have increased. Care should be taken to monitor the implications of outstanding issues and processes such as bail hearings, court cases, action under the Safeguarding Vulnerable Groups Act 2006 including Vetting & Barring, disciplinary hearings, tribunals or action by professional bodies, parole and release dates after prison sentences.

The minutes of the conference should be succinct and contain only essential facts, decisions, recommendations and an outline of the post abuse care plan for those concerned. They will be circulated to participants marked 'Highly Confidential' on a 'need to know basis'. Written reports provided by agencies will not be circulated with the minutes, unless this has been agreed at the meeting. They will be retained in the closed section of the client’s file together with all other adult protection papers related to the case.

In cases where the case conference makes a recommendation that the employer considers taking disciplinary action or making a referral to the Disclosure and Barring Service, the designated senior officer will make a copy of the minutes, or a summary report, available to the employer.
11.7 Establishment case conference

If the investigation has revealed problems related to the general standards of care and/or abusive practices within a service, an establishment case conference may be held. This is likely to be led by the senior manager but there is an expectation that managers from contract services and regulatory authorities play a significant role within the meeting. Outcomes of this conference may result in ongoing auditing, monitoring, enforcement notices or cancellation of the existing registration and the contract. Consideration will be given to the support required to remedy any identified problem areas. Effective communication and collaboration between the police, the social services agency and other relevant agencies are essential.
Accessing Legal Input on Behalf of the Vulnerable Adult

The legislative issues relating to protection of vulnerable adults are complex and may be confusing. The existing legal framework is not wholly effective in protecting vulnerable adults, and provides a blunt instrument when it comes to balancing the issues of autonomy, individual rights and protection.

The Law Commission has addressed these concerns in a series of consultative documents culminating in Law Commission Report No. 231 which was submitted in March 1995 to the Lord Chancellor as the basis for law reform. A report 'Making Decisions' (October 1999) outlines the government's approach to incapacity and provides a new legislative framework for substitute decision making. In April 2005 The Mental Capacity Act 2005 received Royal Assent, this aims to address a wide range of concerns for people who lack capacity.

Meanwhile there are a number of bodies of law that have a bearing on abuse cases and these are listed in guidance section 2. The list is not exhaustive nor does it imply full interpretation of all existing legislation. It is simply a general guide and managers are advised to seek specific individual advice from their legal advisors and/or the local police. In addition responsible managers may seek the support of an independent legal advocate to protect the interests of the vulnerable person where these may run counter to those of the host or purchasing authorities or provider services.
Responsibilities

13.1 What are my responsibilities as a designated senior officer (DSO)?

As the DSO you are responsible for the overall co-ordination and management of an adult protection case and chairing any meetings that may be necessary.

In complex cases involving care services which have been managed as level 4 cases within the framework, the DSO will have been heavily involved in coordinating the various strands of the investigation/assessment processes. It is therefore recommended that consideration be given to commissioning an independent chair for the case conference and any establishment case conferences. (this may be a senior manager from another locality or team)

You should delegate the task of assessment/investigation to an appropriately trained and experienced staff member who will report back to you. This person will be referred to as the investigating officer. You will need to be available to provide support, supervision and advice to the investigating officer and ensure that they have the resources necessary to carry out their task. (Resources include time, clerical support and another person with whom to share the task of interviewing).

If you are the DSO managing the case you are responsible for:

a Seeing that there is a completed alert/referral form on the file and that the completed information is added to the AP data base.
b Ensuring that steps are taken to keep the vulnerable adult safe while initial inquiries are made.
c You will need to decide, from the information available from the initial inquiries, if the vulnerable adult is at continuing risk of significant harm. These initial checks with other agencies and departments will also be necessary to determine whether there are other vulnerable adults or children who may be at risk. It is important that any contacts or visits by care managers, social workers, health staff or regulatory staff do not alert possible perpetrators to the issues of concern unless this is unavoidable.
d Consulting the police if there is a possibility that a criminal offence has been committed. Any emergency action to protect the vulnerable adult may alert the alleged perpetrator resulting in evidence being removed or altered. Hence the police may wish to be involved in any emergency action to preserve forensic evidence or documentation.
e In the event of the death of a vulnerable adult where adult protection concerns already exist or are raised around the time of death, you should ensure that the coroner's office is informed of the adult protection issues as a matter of urgency, if the police have not already done so. The coroner will make arrangements for any investigations considered necessary.
f If abuse is alleged against a staff member who is providing ongoing care or support to vulnerable adults it will be necessary to consider, prior to any planning/strategy meeting, if action needs to be taken to reduce any further risk that this staff member might pose to any vulnerable adults. This may also serve to protect the staff member from further allegations being made against them. You should inform the service's manager as soon as possible about the issues to enable them to take appropriate action to protect all the vulnerable adults within their service. If it is possible that they are implicated in the abuse issues, protective actions will need to take this into account.
g Arranging an appropriate planning/strategy process within 48 hours or as soon as practically possible. The planning process will need to involve all appropriate professionals, agencies, services and departments and any other person who has information essential to the case. This should take the form of a formal planning/strategy meeting if emergency action has been taken or where the factors in section 9.1 are present.
h A formal planning/strategy meeting will allow a full discussion of actions already taken and allow for future planning. Where the allegations involve a staff member from any organisation or agency providing services, a senior representative of the service should be invited to the meeting unless they are personally implicated in the abuse allegations. If, in exceptional circumstances, the service provider has not already been made aware of the allegations of abuse, you will need to ensure that a decision is taken, during the meeting, about informing the service provider of the issues that need to be investigated/assessed.
i Liaising with the commissioning service, where appropriate, regarding the status of the contract and deciding with them whether any action is needed in relation to the contract, either before or after the investigation has taken place; (See protocols section 8.1 Risk/Protection).

j Ensuring that, where appropriate, placing authorities are informed of adult protection concerns in a care setting which might affect their clients. This will enable them to be involved in meetings and assessments as necessary.

k Ensuring that a complete record of all contacts, meetings, phone calls, interviews and decisions are kept in the closed/restricted part of the client's file.

l Ensuring that there is a record of the decisions taken as a result of a formal planning/strategy meeting and/or recording the outcome of initial post alert consultations.

m Ensuring that any assessment/investigation carried out with or without the support of other agencies is fully recorded and that there is a written summary of the findings on which to base decisions.

n Chairing the case conference and ensuring that full support is available for any vulnerable adults attending the conference. This is a major responsibility and the DSO should have appropriate training and support to undertake the task. (See guidance section 33)

o Ensuring that the minute-taker is appropriately trained and skilled at this task. They should be identified in advance of the meeting and be updated regarding the case and possible issues that are likely to arise. (See guidance section 34)

p Ensuring that appropriate pre-conference support has been provided to the vulnerable adult and/or his/her representatives in the case conference. You have the authority, in consultation with the vulnerable adult and other representatives, to restrict or exclude attendance of people at the conference if they are likely to prevent a full and proper discussion. This should be clearly recorded in case conference notes.

q Ensuring that decisions taken, at a case conference or other review meetings, are minuted including decisions concerning:

- the vulnerable adult(s) or children;
- the person responsible;
- the service setting/agency.

r As the chair of the planning/strategy meeting or case conference you should take responsibility for recommending that the employer makes a referral to the Disclosure and Barring Service (DBS) in appropriate cases. In cases where the employer does not intend to make the referral the local authority under the Safeguarding Vulnerable Groups Act (2006) has a responsibility to make a referral to the DBS where they consider that the DBS may barr the person.

- If the employer is reluctant or refuses to make the referral, this should be reported to the Care Quality Commission (CQC) who will take responsibility for following this up with the employer.
- This information should then be recorded in the adult protection papers for the client(s) who was the subject(s) of the adult protection case(s).

s Ensuring that action points from formal meetings are circulated within 2 working days. It is good practice for the full minutes to be circulated within 10 working days unless exceptional circumstances make this impossible.

Where an inquest or court case is likely the DSO must alert senior managers in all agencies involved in the case. It is the responsibility of these senior managers to consider accessing legal advice/support for all potential witnesses from their organisation/service. It is also recommended that witnesses have appropriate management and pastoral support when attending court.
13.2 What are my responsibilities as the investigating officer?

The role of the investigating officer is central to the adult protection process. If you are asked to be an investigating officer for a case you should have an understanding of the multi agency adult protection policy and protocols and be appropriately trained and experienced to undertake the task.

* Where the investigating officer is not a representative of the Social Services Agency, the Designated Senior Officer (DSO) will take responsibility for completing the alert/referral form and ensuring information is added to the database. They are also responsible for maintaining a complete record of contacts in relation to the case.

The responsibilities of the investigating officer assigned to co-ordinate the assessment and the investigation are to:

a. * Ensure that an appropriate alert/referral form has been completed by the professional receiving the initial information and that this is updated on the form and data base as additional information becomes available.

b. * Ensure that the adult protection data has been entered onto the adult protection section of the client database.

c. Ensure the safety of the vulnerable adult(s) in liaison with the DSO.

d. Ensure that the wider issues of communication, language, culture, religion and gender are taken into account when planning investigation/assessment.

e. * Ensure that a complete record of contacts, meetings, phone calls, interviews and decisions is made and kept in the closed section of the client's file.

f. Carry out an assessment/investigation with other agencies where appropriate and writing a summary of the findings to aid decision-making. (See Investigation/Assessment checklist in guidance section 24.)

g. Carry out any other actions identified through the planning, investigation and assessment process.

13.3 What are my responsibilities as a formal or informal carer, a social worker or health professional, a police officer, a volunteer, manager or staff member in a statutory, private or voluntary organisation or a member of the public, if I believe that a vulnerable adult is being abused?

The following points may assist you to consider actions that may need to be taken to support the multi-agency adult protection protocols:

a. Everyone has a duty to report any allegations or suspicions of abuse or potential abuse of a vulnerable adult either to their immediate line manager or to discuss their initial concerns with the social services agency, the regulatory authorities or the police.

b. This includes not only abuse identified within a service but also abuse carried out by anyone else.

c. Health and social care professionals may identify adult protection concerns during the normal course of their work. These should be reported through the adult protection processes. They should support the adult protection processes by attending relevant adult protection planning/strategy meetings, case conferences and supporting any post abuse work allocated to them.

d. If you are employed in a caring capacity and have reason to believe that your line manager is colluding in the abuse you may report your concerns directly to the social services agency, to the regulatory authorities or to the police. You may prefer to follow the whistleblowing procedures in your own agency. The person receiving the information under the whistleblowing procedures must take responsibility for ensuring that the issues are addressed appropriately. (See whistleblowing guidance section 13). If they decide that an adult protection referral should be made to the social services agency, they may decide to withhold the name of the member of staff who originally identified the abuse.

e. If the alleged abuser is also a service user then a member of staff will need to be allocated to attend to their needs and ensure that they do not pose a risk to other vulnerable adults.
f In the event that Police have been called, care must be taken to preserve evidence, especially in cases involving physical or sexual abuse. (See guidance section 15).

g No staff within the service should alert or confront the alleged abuser if to do so would place anyone at risk of harm or risk contamination of evidence.

h An accurate detailed record of the adult protection concern should be made as soon as possible. (Information about responding to disclosures is included in guidance section 4). Care must be taken to ensure that the recording is kept in a secure place to ensure that an alleged abuser does not have access to it. This could compromise any investigation.

i If the alleged abuser is a member of staff or a volunteer, consideration must immediately be given to protecting the vulnerable adult(s) and children from the possibility of further abuse until the issues have been investigated. If you are the manager you are advised to use your internal staff disciplinary procedures to safeguard the interests of both the vulnerable adult(s) and the staff member(s) concerned. Discuss your actions with the regulatory authorities.

j If an adult protection referral has been made to the social services agency or to the police, if a crime is suspected, no attempts should be made, by the service, to question the vulnerable adult(s) or other vulnerable witnesses. This will be done as part of a formal investigation and or assessment of the issues which will be agreed as part of the adult protection planning process. The service provider should be involved in the planning and investigative processes and attend meetings unless there are very clear reasons to suspect that their involvement would compromise any stage of the process.

k There is an expectation that managers and staff providing services to vulnerable adults will cooperate fully in any adult protection investigation/assessment and comply with any recommendations made in a post abuse action plan.
13.4.1 What are my responsibilities as a representative of the commissioning team

The commissioning processes aim to ensure good standards within service settings. The contract monitoring processes should identify any deviation from agreed standards. These processes could also identify that a service user(s) has suffered or could suffer significant harm due to bad practice, negligence, accidental or deliberate actions of the service provider, their staff, volunteers or other service users.

Commissioning processes require service providers to have their own adult protection procedures in place to deal with issues of concern regarding abuse or suspected abuse. These procedures do not replace the Kent and Medway Multi-Agency Protocols but should act to complement and support them.

a. Any concerns about the abuse of individual service users or possible abuse noticed or reported to you should be reported to the appropriate social services agency or the designated senior officer for the appropriate client group.

b. If a staff member(s) who is providing ongoing care or support to vulnerable adult(s) is implicated, it may be necessary to consider, prior to any planning process, if action needs to be taken to reduce any further risk that this staff member might pose to any vulnerable adults or children. If this appears to be the case initial discussion with case management staff should take place to determine who advises the service's registered manager/provider of the adult protection issue. Where the allegation refers to abuse by a staff member within any service or agency, the designated senior officer or commissioning staff should inform the employer.

c. There will need to be a consideration within the planning process of the level of risk that exists in relation to the allegations within the service provision. (See protocols 8.1) It is important to ensure that the service provider has been informed in writing of any issues that effect their contract.

d. Commissioning staff should support the adult protection process by attending any relevant planning/strategy meetings and carrying out any actions agreed during the meetings.

e. If it is necessary to obtain details of some or all of the service users in order to advise their funding authorities of the adult protection concerns, the designated senior officer should obtain the information from the service provider.

f. Where appropriate, commissioning staff should support any actions agreed in the post abuse care plan. They may be asked to ensure that any agreed changes to the management, staffing or service standards have taken place.

g. Close liaison should be maintained between commissioning staff and the designated senior officer with regard to any service contract changes necessary throughout the process.

13.4.2 What are my responsibilities as a member of the Regulatory Authority, The Care Quality Commission (CQC)

a. CQC are responsible for setting essential standards of safety and quality by registration and by the ongoing monitoring of providers compliance.

b. They will use a range of enforcement powers where registration requirements are not being met. Particularly focussing of services that are delivering poor quality outcomes.

c. Where CQC identify safeguarding concerns in the course of their regulatory duties they will advise the local authority by sending a safeguarding referral form.

d. When the local authority are made aware of a safeguarding concerns in regulated services they will advise CQC and invite them to be part of the planning process.

e. CQC will either attend the planning/strategy meeting or provide to the DSO any relevant information required to support safeguarding activity.

f. For more information about the role of CQC see CQC’s “Our Safeguarding Protocol” February 2013.
13.5 What are my responsibilities if I believe that someone has been abused in a service provided by an acute hospital trust?

a In line with the Care Quality Commission Safeguarding Adults Protocol and Guidance, protocol section 17 has been developed to ensure that abuse occurring within these services are recorded, monitored and the actions taken by the Trust are quality assured through the local authority adult protection processes.

b Acute Hospital Trusts have responsibility to co-ordinate actions to deal with allegations of adult abuse which occur in services provided by the Trust. They may ask social services hospital care management teams for advice, to provide an advocate for the patient, to support the family and to support any post abuse care needs.

c If you are a visitor to the hospital and you witness abuse or suspect abuse to have occurred within the hospital, you should immediately report your concerns to a senior manager in the hospital. You may report your concerns to the police, the Patient Advice and Liaison Service (PALS), the relevant Clinical Commissioning Group or to the Social Services Agency if you believe that your concerns have not been taken seriously.

d If you are a member of the hospital staff you must follow the Trust's adult protection procedures. If you do not believe your concerns have been taken seriously you may contact the Police, Social Services, the Clinical Commissioning Group, the Care Quality Commission or the Health Ombudsman.
13.6 What are my responsibilities as an employer?

Employer is used as a generic term and includes all key personnel involved in the management of the service.

a. You will ensure that your service has its own adult protection procedures that are complementary to the multi-agency adult protection protocols.
b. You are responsible for ensuring that all service users are safeguarded from abuse.
c. All allegations and incidents of abuse are followed up promptly and actions recorded.
d. You should use the measures available to you through your internal staff disciplinary procedures to ensure the safety of all service users pending investigation/assessment of the concerns.
e. In considering whether it is necessary to report a concern about a possible adult protection matter to the social services agency, you should consider the contents of protocols sections 4.7 and 4.8.
f. All matters which have a bearing on the safety and wellbeing of a vulnerable adult must be reported to the regulatory authorities and the commissioners of the service for the individual(s) involved.
g. If the concerns need to be reported to the social services agency and/or to the police, it is important that any internal staff disciplinary processes do not contaminate any evidence which may be gathered as part of the multi-agency investigation/assessment.
h. The paramount consideration must be to protect vulnerable adults in your care however, it is important to ensure that any action taken in accordance with internal staff disciplinary procedures is compliant with best practice in employment legislation and the Human Rights Act 1998.
i. You will be involved in the adult protection planning/investigation processes unless there are concerns/allegations that you may be directly implicated or your involvement at the planning stages may impede the investigation/assessment.
j. In accordance with the Safeguarding Vulnerable Groups Act (2006) you must refer employees and volunteers undertaking regulated activities with vulnerable adults (according to the definitions within the Act) to the Disclosure and Barring Service (DBS), for consideration for inclusion on the Barred List, if they pose a risk to vulnerable adults or children. (See guidance section 30).

13.7 What are the responsibilities of the crown prosecution service?

When the police have gathered all available evidence, unless the crime is of a minor nature and the offender admits it, they will refer the file to the Crown Prosecution Service for pre charge advice.

a. The CPS will review the matter within agreed timescales in accordance with the Code for Crown Prosecutors and the CPS policy and guidance on prosecuting domestic violence, disability hate crime and crimes against older people. They will also take account of any local protocols to which the CPS has signified its agreement. The advice will be issued to the police for them to take any further action.
b. If a prosecution is started, but in the course of continuing review, a decision is taken not to go ahead, the Crown Prosecutor who makes that decision will write to the victim to explain the reason for the discontinuance. In cases of violence or sexual abuse where discontinuance is being considered, a second opinion will be sought from another experienced prosecutor before any action is taken.
How Do We Learn from Experience in Adult Protection Cases?

14.1 Monitoring

It is essential that systematic monitoring of various aspects of adult protection be conducted on a regular basis in each locality and at a county level.

Different agencies will be able to contribute to the information by making sure that they keep information in compatible systems and access their own data sets for the purpose of planning protective services.

Knowledge in your area can draw on a number of sources:

- Numbers of referrals received under adult protection.
- Vulnerable victims of crime where these are identified in generic crime statistics and/or analysed within community safety initiatives.
- Cancellations and enforcement actions taken by the regulatory bodies.
- Disciplinary or professional misconduct hearings.
- Disclosure and Barring Service referrals and outcomes.
- Criminal Convictions and the result of Civil actions following adult protection cases.

Aggregation and analysis of quantitative and qualitative information relating to adult abuse should assist in several ways:

a To raise the profile of adult protection.

b To inform senior managers and elected members.

c To monitor the workloads of staff in social services, police, health and voluntary organisations.

d To ascertain possible resource implications in managing adult protection effectively and bidding for additional resources.

e For pro-active planning and development of adult protection training and services in conjunction with other agencies.
14.2 Case review

From time to time it is important to review individual cases to learn about the process of investigation and to revisit these procedures in the light of experience. This process could act as a debriefing for all staff involved in a particularly difficult or stressful case.

Where there are serious concerns about the way a case has been addressed, any agency or person may request that the case be referred for a Serious Case Review. (There are separate procedures for the Serious Case Review process and these can be viewed Serious Case Review Procedures).

The following template (adapted from Brown, Flynn and Maugham 2000) provides an agenda for such a reflective review.

Twelve questions to ask when reviewing cases reported under adult protection policies.

1. Was the policy triggered appropriately, at the right time, through the appropriate channels and to the right person/agency?
2. Did the proper person at a proper level, that is by someone with sufficient seniority, impartiality and authority carry out the investigation?
3. Was the input of each agency properly co-ordinated?
4. Was the vulnerable adult appropriately safeguarded throughout the investigation process?
5. Were the rights of other people e.g. staff, relatives and other service users, properly respected throughout the investigation. For example, where a member of staff was suspended, were the proper procedures used?
6. Were appropriate inquiries/assessments made and was sufficient background information collated according to an agreed timetable and within appropriate deadlines?
7. Were sound decisions made and recorded at a case conference or other forum concerning:
   * Findings of fact, such as the substance of allegations and whether the evidence supported, was insufficient or disproved the allegations?
   * The ongoing protection of the vulnerable adult?
   * Appropriate sanctions and support for the person alleged responsible?
   * Action in relation to the service for example using the powers within the Care Standards Act 2000 or revised contracts?
   * Reviewing management and practice in terms of the failure to prevent abuse and changes needed to protect vulnerable people in the future? and
   * At organisational level in terms of strategic service development and management?
8. Was the case followed through at all these levels? Did the case conference set out indicators, which should trigger further concern or action? Were dates set for review and further action planning?
9. Has there been any further abuse of this person, by this person or in this service since the case conference?
10. Have any good things come out of the case for any of these people or at any of these levels?
11. Were investigators/assessors properly supported throughout the process?
12 What have we learnt and what would we do differently next time?

An audit tool has been included in the guidance section 31 to assist agencies to review the process for individual cases.
How Can Our Agency/Service Contribute to Adult Protection Work?

Your agency/service may contribute to adult protection work across the County in a number of ways. These might include:

- Strategic planning around implementation, dissemination and development of these protocols.
- Identifying resources which can be used to fund shared projects, staff posts or training initiatives.
- Supporting joint training initiatives on identification of abuse, responding to it and supporting investigative and assessment processes.
- Identification of specific expertise such as interpreting skills and/or clinical skills which can be used in the context of assessment/investigation such as speech and language therapy, psychological assessment of capacity and planning how this expertise can be promptly accessed.
- Development of specific working arrangements for areas of joint work within these protocols.
- Identify an appropriate person to receive papers and documents about adult protection and to comment on behalf of your agency/service. This manager should be nominated as the lead for adult protection within the agency/service and should ensure training, support, advice and guidance is available to staff where adult protection issues arise.
- Ensure there are specified measures to promote quality and minimise the risk of abuse in settings for which your agency/service is responsible.
- Support the development of services for vulnerable people who have been abused and/or extend existing services to more vulnerable client groups, where these have already been set up to respond to the needs of people who have been abused or traumatised.
- Identifying and mandating a representative to contribute to the Safeguarding Vulnerable Adults Board.
Adult Protection Consultation/Referral Protocol
Between Police and The Social Services Agency

Adult Protection Alert Form Completed
Stage 1
Evaluation of information and consultation
with other agencies and services

Stage 2
Are there any criminal issues?

Yes
Possibility
No

Formal referral to police PPU by phone followed by alert form sent by secure email. Discussion about process. Police will attend planning/strategy meeting.

AP process continues without police involvement

Should concerns emerge that a crime may have been committed the police should be contacted immediately.

Guidance Notes On Consultation
AP is a multi-agency responsibility. The Social Services Agency has a co-ordinating role and has a ‘Duty of Care’ to act in the ‘Best Interests’ of vulnerable adults. In order to do this consultation should be carried out with any agency/service who may have information regarding the victim(s), alleged abuser(s) and locality(s) of abuse. Outcome of consultations must be recorded. Contact must include the police if there is any possibility that a crime may have been committed. In discussion with the police explain the AP concerns and any additional information gathered. Ask if, from the information available, crime is or may be an issue. Information held by other agencies should assist in the evaluation of the concerns reported and in planning appropriate responses.

GOOD PRACTICE PRINCIPLES
The views of the vulnerable adult will always be considered but where a crime is believed to have been committed the police must be contacted as they have a central role in criminal matters. A vulnerable adult who has capacity, is not being intimidated or pressurised and understands the risk issues may decide that they do not want to support a criminal investigation. If there are any doubts regarding their capacity to make this decision or their understanding of the risk factors or if other vulnerable adults or children may be at risk then the wishes of the vulnerable adult may be over-ridden. A police officer will carry out a joint visit with an appointed health or social care representative in all cases where a crime is believed to have been committed. This will ensure that the decision taken by the vulnerable adult(s) has been taken with a full understanding of all the issues.

IF IN ANY DOUBT THAT THE CONCERNS CONSTITUTE A CRIME CONSULT THE POLICE.

Approved by Adult Protection Board 15/06/05

Amended January 2012
Guidance Notes for Adult Protection Protocol between Adult Social Services in Kent and Medway and Acute Hospital Trusts

Flowchart 17a summarises the most appropriate response to adult protection concerns arising within services managed by Acute Hospital Trusts.

For safeguarding adults concerns arising in services managed by the acute hospital Trusts the Hospital Adult Protection Lead Manager (HAPLM) will be the responsible Designated Senior Officer (DSO) for the Case unless the Trust delegated the responsibility to another manager for a particular case.

This protocol aims to ensure that there is equality and transparency in addressing adult protection concerns wherever they occur. It will also ensure that the data collected includes allegations of abuse that may previously have been dealt with as complaints or through hospital discharge processes.

Concerns Reported Directly to Adult Social Services.

Allegations of possible abuse occurring in services managed by Acute Hospital Trusts may be reported to social services through their duty service or any other route including their complaints system. It is the responsibility of the person receiving the information to discuss the reported concerns with their Line Manager or a Designated Adult Protection Specialist. If the issues are considered as possible abuse it is the responsibility of the Line Manager to ensure that an alert/referral form is started and that the information is entered onto SWIFT/FRAMEWORK.

The information (via a copy of the alert/referral form) must be passed by secure e-mail as a matter of urgency to the Hospital Adult Protection Lead Manager (HAPLM) for the Hospital concerned. The HAPLM or a senior manager in the hospital must be contacted by phone to ensure that they are aware of the alert information being passed to them.

If it is possible that a crime may have been committed the HAPLM must consult with the Police at the earliest opportunity to determine the most appropriate course of action. If for any reason there is any delay in making contact with the HAPLM, the Line Manager from Adult Social Services who decided that the concerns warranted an adult protection alert must alert the Police to the concerns. Early Police notification may prevent further harm and/or valuable forensic evidence being lost.

The Hospital Care Management Team must also be informed of the concerns and advised that the information has been passed to the HAPLM or a senior manager in the Hospital Trust.

If the vulnerable adult has been placed in a care home in Kent or Medway by another authority the care home should be asked to advise the placing authority of the adult protection concerns.

If the vulnerable adult was visiting Kent or Medway and is normally a resident in another authority area and the HAPLM becomes aware that the person is normally in receipt of social care services from that other authority then they should inform the other authority as a matter of courtesy.

It is the responsibility of the HAPLM to determine the most appropriate course of action. It is usual for the HAPLM to act as the DSO in these cases. However if there is any possibility that a crime may have been committed, or other agencies are involved the HAPLM should consider holding a multi-agency planning/strategy meeting to ensure that roles and responsibilities are clearly defined and delegated. Adult Social Services representatives may be asked to provide support to the patient and/or their family during the investigation/assessment of the concerns.

When the investigation/assessment has been completed the HAPLM should complete the monitoring information on the alert/referral form. They should also complete a closure/form summarising the result of the investigation/assessment of the case and any actions agreed. The form(s) together with copies of any evidence gathered should be passed to the Hospital Based Care Management Team. This team should ensure that the monitoring information is entered onto SWIFT/FRAMEWORK. The papers should then be passed to the Community Based Adult Social Services Senior Manager/Service Manager for the locality/area where the alleged abuse occurred. This manager will be responsible for countersigning the closure form and ensuring that the information is fully entered on the SWIFT/FRAMEWORK.

Amended January 2014
If the Adult Social Services Senior Manager/Service Manager has any concerns about any aspect of the case they must liaise with the HAPLM prior to endorsing the closure form.

Adult Social Services remain responsible for ensuring that adult protection concerns are addressed appropriately. In Kent and Medway the Community Based Senior Manager/Service Manager is accountable for this process.

**Concerns Reported to Hospital Trust Staff**

Allegations of abuse occurring in a service managed by an Acute Hospital Trust may be reported to any member of the Trust’s staff. They should discuss the reported concerns with their Line Manager and/or the HAPLM and record the outcome of the discussion. In some cases the report may be made following the discharge of a patient from the hospital and may initially be considered to be a complaint. It will be important for any matters that may constitute adult abuse to be discussed with the Line Manager who may wish to consult with the HAPLM for guidance. If the matter is considered as possible abuse the Line Manager or the HAPLM must record the information they have on an alert/referral form. If they consider that a crime may have been committed they must liaise with police as a matter of urgency. The outcome of the consultation with the Police and any other agencies/services must be recorded on the alert/referral form. If the vulnerable adult has been placed in a care home in Kent or Medway by another authority, the other authority should be advised of the concerns reported.

They must pass this form via secure e-mail to the Central Duty Team for Kent Acute Hospitals or to Medway Access and Information for Medway Maritime Hospital. The alert information must be recorded on SWIFT/FRAMEWORK as soon as the information is received.

A copy of the alert/referral form (marked copy) should be e-mailed to the Hospital Care Management Team by social services for their information.

It is the responsibility of the HAPLM to determine the most appropriate course of action. It is usual for the HAPLM to act as the DSO in these cases. However if there is any possibility that a crime may have been committed, or other agencies are involved the HAPLM should consider holding a multi-agency planning/strategy meeting to ensure that roles and responsibilities are clearly defined and delegated. Adult Social Services representatives may be asked to provide support to the patient and or their family during the investigation/assessment of the concerns.

When the investigation/assessment has been completed the HAPLM should complete the monitoring information on the alert/referral form. They should also complete a closure/form summarising the result of the investigation/assessment of the case and any actions agreed. The form(s) together with copies of any evidence gathered should be passed to the Hospital Based Care Management Team. This team should ensure that the monitoring information is entered onto SWIFT/FRAMEWORK. The papers should then be passed to the Community Based Adult Social Services Senior Manager/Service Manager for the locality/area where the alleged abuse occurred. This manager will be responsible for countersigning the closure form and ensuring that the information is fully entered on the SWIFT/FRAMEWORK.

If the Adult Social Services Senior Manager/Service Manager has any concerns about any aspect of the case they must liaise with the HAPLM prior to endorsing the closure form.

Adult Social Services remain responsible for ensuring that adult protection concerns are addressed appropriately. In Kent and Medway the Community Based Senior Manager/Service Manager is accountable for this process.

Adult Social Services remain responsible for ensuring that adult protection concerns that happen in their authorities area are addressed appropriately.

**WHAT IF THE ALLEGATIONS OF ABUSE APPEAR, FOLLOWING INITIAL EVALUATION, RISK ASSESSMENT AND CONSULTATION BY THE LOCAL AUTHORITY OR FOLLOWING FURTHER ENQUIRIES BY THE HAPLM, TO RELATE TO THE ACTIONS OF A MEMBER OF THE PUBLIC, A FAMILY MEMBER OR PERSONNEL FROM ANOTHER AGENCY OR SERVICE?**
In these circumstances it is advisable to discuss the case with the local Adult Social Services Team who may be in a better position to co-ordinate the response to the reported concerns in partnership with the Trust and where appropriate with the Police.

Contact Details for Nominated Hospital Adult Protection Lead Managers:

**Darenth Valley NHS Hospital Trust:**
Lead Nurse for Adult Protection 01322 428595
Or ask for the Director of Nursing

**East Kent NHS Hospital Trust:**
Head of Adult Safeguarding, PREVENT Lead Mobile 07964437558
or Director of Nursing or Lead Nurse for Safeguarding Adults: 01843 225544
Or ask for a site based Matron
Out of Hours Ask for the Site Clinical Nurse Manager at relevant hospital

**Maidstone and Tunbridge Wells NHS Hospital Trust**
Ask for Safeguarding Lead Nurse – Karen Davies
Maidstone—Christine Steele 01622 729000
Pembury and Kent & Sussex--- 01892 526111

**Medway NHS Foundation Trust**
Chief Nurse’s Office
Windmill Road
Gillingham
Kent ME7 5NY
Tel: 01634 833897 or 833788
OR
Safeguarding Vulnerable Adults Coordinator
Tel: 07884181615.

**Contact Number for Police: 101**
In office hours: ask for the police in the relevant Combined Safeguarding Team
Out of hours: Ask to speak to an officer for advice regarding the possible abuse of a vulnerable adult.

**Contact details for Kent Adult Social Services**
24 hour contact centre: 03000 41 11 11

**Contact Details for Medway Adult Social Services**
Day time: 01634 334466
Out of Hours: 03000 41 91 91
The responsibility for initiating an adult protection alert/referral form will rest with the agency staff / managers receiving the initial information that a vulnerable adult **may have** been the victim of abuse. For safeguarding adults concerns arising in services managed by the acute hospital Trusts the Hospital Adult Protection Lead Manager (HSC) will be the responsible Designated Senior Officer (DSO) for the Case unless the Trust delegated the responsibility to another manager for a particular case.

**Reported to Adult Social Services**

**Action to be Taken**

- Discuss concern with line manager or Designated AP specialist
- If abuse possible start alert/referral form
- Enter information onto SWIFT/FRAMEWORK
- Send copy of alert/referral form to HSC and phone to confirm receipt
- If possible crime HSC must consult with Police
- If any delay in contacting HSC and possible crime, Adult Social Care must alert the Police.
- Inform hospital care management team of the concerns
- If person placed in care home by another Authority the HSC should advise that commissioning authority.
- If the person is ordinarily resident in another LA area and is receipt of social care services the HSC should advise the other LA.
- The HSC determines the most appropriate course of action via strategy discussion/meeting
- Investigation/assessment carried out and outcome agreed and recorded
- HSC completes the monitoring and closure details on the relevant form(s)
- All relevant papers should be passed to Hospital care management team
- Hospital care management team enter monitoring information into SWIFT/FRAMEWORK
- All papers should be passed to community based adult social services senior /service manager where the hospital is based
- Manager countersigns the closure form and ensures information is entered onto SWIFT/FRAMEWORK

**Reported to Acute Hospital Trust**

**Action to be Taken**

- Discuss concern with line manager and or HSC
- If abuse possible start alert/referral form
- If possible crime HSC must consult with Police
- Send form to CDT for Kent Acute Hospitals or Medway Access and Information for Medway Maritime Hospital
- Adult social care will ensure that the alert information is entered onto SWIFT/FRAMEWORK
- Social services will inform hospital care management team of the concerns
- If person placed in care home by another Authority the HSC should advise that commissioning authority.
- If the person is ordinarily resident in another LA area and is receipt of social care services the HSC should advise the other LA.
- The HSC determines the most appropriate course of action via strategy discussion/meeting
- Investigation/assessment carried out and outcome agreed and recorded
- HSC completes the monitoring and closure details on the relevant form(s)
- All relevant papers should be passed to Hospital care management team
- Hospital care management team enter monitoring information into SWIFT/FRAMEWORK
- All papers should be passed to community based adult social services senior /service manager where the hospital is based
- Manager countersigns the closure form and ensures information is entered onto SWIFT/FRAMEWORK

If following the initial assessment of the concerns by the HSC (Hospital Safeguarding Coordinator) it becomes apparent that the allegations relate to actions by:

- a member of the public, a family member or personnel from another agency/service, it may be more appropriate for the Local Authority to co-ordinate the response to the adult protection concerns in partnership with the Trust and where appropriate with the Police.

Amended January 2014
What if an adult protection alert includes allegations of fraud or deception by an NHS service or a staff member employed by an NHS body?

All adult protection concerns that may also be a crime must be the subject of consultation with the police see protocol section 16.

- It is the responsibility of the police to alert the NHS counter fraud service of the adult protection concerns. (see guidance section 36)

- If appropriate an NHS counter fraud service (NHSCFS) representative should attend or send a report to an adult protection planning/strategy meeting. This will ensure that there is clarity regarding the responsibilities of carrying out various aspects of the investigation and the assessment of the impact on the vulnerable adult.

- When the investigations and assessment are completed a case conference should be convened involving the NHSCFS this will ensure effective feedback to all concerned.

If as a part of any investigation carried out by the NHSCFS they identify that a vulnerable adult (No Secrets definition) is involved the NHSCFS will contact the local authority to inform them of the concerns which may result in an adult protection alert being raised.
**Protocol for Determining Causative Factors of Pressure Ulcers in Adult Protection Investigations**

**Introduction**
The purpose of this protocol is to support Multi-agency decision making when considering whether or not to raise an adult protection alert for an individual presenting with one or more pressure ulcers. The main issue to consider before raising an alert is, “was the pressure ulcer most likely to have been preventable?”

**Incident Reporting**
Each provider must have their own procedures for incident and pressure ulcer reporting, which fulfills all local and statutory reporting requirements whilst providing the framework for reporting pressure ulcers as an adult protection alert in line with this multi agency protocol.

**Process**
The process is covered within Thresholds for Reporting Adult Protection Concerns re: Pressure Ulcers

**Factors to Aid Decision-making (contributory factors)**

Are covered within Thresholds for Reporting Adult Protection Concerns re: Pressure Ulcers and the Threshold Guidance

The identified factors established determining events (tier 1) leading up to the pressure ulcer development must be recorded to provide information for the adult protection investigation process

For more information please use the following link: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125233.pdf
(Annex two and three provide further guidance in decision making)

You should consult with your line manager and if appropriate the local authority as per contacts provided in Thresholds for Reporting Adult Protection Concerns re: Pressure Ulcers.

In the community setting including residential and domiciliary care where a nurse is not already involved please refer to the persons General Practitioner for further support.
PRESSURE ULCER THRESHOLD GUIDANCE

Each Provider must have their own procedures for incident and pressure ulcer reporting, which fulfils all local and statutory reporting requirements whilst providing the framework for reporting pressure ulcers as an adult protection alert in line with the multiagency protocol.

The examples below provide a limited illustration of managing concerns about pressure ulcers and indicate the possible range of severity.

**Lower Level Pressure Ulcer Concern**
(Remember the cumulative effect of low level concerns may lead to harm)

- Isolated missed home care visit - no harm occurs
- Minor events that still meet criteria for ‘incident reporting’
- Patient not concordant with assessed care plan
- Involuntary carer requiring additional support to meet vulnerable adult’s needs
- MCA has been considered in least restrictive approach to manage pressure area care
- Patient's co-morbidities are such that PU development would have been likely
- Patient was receiving planned and well provided end of life care

<table>
<thead>
<tr>
<th>Significant Concern Remains / Serious Concerns confirmed AP1 completed</th>
<th>Very Significant Harm</th>
<th>Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Incident investigation prompted</td>
<td>Inexplicable Pressure Ulcer development and deterioration within a care setting or where the person is supported with personal care by paid worker.</td>
<td>Inexplicable pressure ulcer Establishment of facts supports that there is no appropriate management of contributory factors.</td>
</tr>
<tr>
<td></td>
<td>Transfer of care where as a result of inadequate sharing of information and planning harm occurs</td>
<td>The concerns identified in this case may have implications for others in receipt of care from the same team or agency.</td>
</tr>
<tr>
<td></td>
<td>Rigid/inflexible routines which fail to provide individual care needed.</td>
<td>There are known reports of other vulnerable adults developing inexplicable pressure sores by the same care provider(s).</td>
</tr>
<tr>
<td></td>
<td>Failure to whistle blow on serious issues when internal procedures to highlight issues are exhausted</td>
<td>Ongoing lack of care to extent that health and well-being deteriorate significantly e.g. pain, category 3/4 pressure ulcers, dehydration, malnutrition, loss of independence/confidence</td>
</tr>
<tr>
<td></td>
<td>Failure to refer disclosure of abuse</td>
<td>Bad practice not being reported and going unchecked</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failure to support vulnerable adult to access health, care, treatments</td>
</tr>
</tbody>
</table>

Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death

- Failures in reporting severe deterioration of pressure ulcer for further health opinion.
- Coroner reports cause of death attributable to pressure ulcer
- Mental Capacity Act not observed in supporting best interests as related to health care
- Failure to arrange access to life saving services or medical care
- Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk
- Widespread, consistent ill treatment
- Professionals involved fail to follow their code of conduct

Information from Safeguarding Adults; The Role of Health Service Practitioners (Department of Health 2011) (page 51) may help in decision making process.
Adult Protection

Guidance
Preventative Strategies

The policy and protocols on definitions, recognition, risk factors and actions to be taken when abuse is suspected. It is important to remember that the ultimate intention of developing an adult protection strategy is to prevent the abuse of vulnerable adults.

Consideration of the following factors should assist in preventing or minimising the risks of abuse occurring.

a) Helping vulnerable adults to protect themselves from abuse:

- Families, carers, schools, colleges and service providers should ensure that vulnerable adults receive information about what constitutes abuse.

- It is important to ensure that information is available to assist vulnerable adults to understand the role of trading standards and the police in dealing with rogue traders, bogus callers and distraction burglars.

- User groups are supported to enable vulnerable adults to talk about issues that concern them.

- Self-advocacy schemes are available to support vulnerable adults to disclose abuse and to talk about other issues which concern them.

- Advocacy schemes are available to speak up or take action on behalf of vulnerable adults, when necessary.

- Information is available, accessible and understandable to vulnerable adults.

- That where possible vulnerable adults share in any decisions which affect their lives.

b) How staff and carers can minimise risk by:

- Developing an understanding of the issues which constitute abuse.

- Acknowledging that ‘it could happen here’

- Having open and honest discussions about care issues and concerns.

- Being aware of the issues of vulnerability.

- By investing in training and development of skills.

- Supporting a learning culture, by giving feedback within the staff team.

- By being prepared to question care practices that could be abusive.

c) How the service or setting can minimise risk by:

- Having an Adult Protection Policy.

- Having a Whistle Blowing Policy.

- Effective employment and recruitment practices.

- Having pre-placement assessments carried out to ensure that the service can meet the identified needs of the service user.
- Developing individual care plans and risk assessments to identify how the service and carers will meet identified needs.
- Having the care plans and risk assessments agreed and signed up to by all relevant parties.
- Ensuring that staffing levels and competence can meet the needs of the service users.
- Encouraging good communication between staff and managers.
- Encouraging good communication between service users, families and professional agencies.
- Recording complaints and responding to them in a positive manner and recording outcomes.
- Ensuring that staff and volunteers receive training to understand what constitutes abuse.
- Support training initiatives about all areas of care.
- Having efficient reporting and recording systems in place.
- Considering if apparently isolated incidents might be a reflection of problems within the organisation.
- Having clearly understood channels of communication.
- Having clear and easily accessible policies which promote good practice.
- Ensuring that staff receive regular and recorded supervision.
- Appropriate links are made with other agencies.
- Being prepared to listen and to respond to staff, users and carers when care practices are questioned.
- Information about standards of care or issues of concern are discussed internally and externally when appropriate.
- Visitors are welcomed and service users are supported to access community facilities.

d) How contractors, commissioners and regulators can minimise risk by:
- Ensuring that a care plan contains a properly documented needs analysis.
- Ensuring that the contract for care, records the exact care required for the service user.
- Ensuring that the service chosen can meet the needs of the service user.
- Monitoring service delivery from differing perspectives.
- Reviewing the care standards regularly with the service users.
- Listening to the service users views about the service.
- Listening to care staff and families views about the service.
- Ensuring that all contracted services recognise the need to train staff to understand the issues of adult abuse.
- Reporting and recording concerns about possible abuse through the adult protection process.
e) Helping Direct Payments scheme users to protect themselves from abuse

**Government guidance**

The 'No Secrets' guidance for the protection of vulnerable adults from abuse includes specific instructions concerning the users of Direct Payments schemes, which recognises the possibility of increased risk of abuse that exists for these people:

'Anyone who is purchasing his or her own services through the Direct Payments system and the relatives (or person managing the Direct Payments on behalf of the individual) should be made aware of the arrangements for the management of adult protection in their area so that they may access help and advice through the appropriate channels. Care managers, who play a role in Direct Payments, could be asked to help users who are at risk of abuse.' (No Secrets DOH 2000:7.9)

Personal Assistants employed directly by service users through the Direct Payments scheme are not subject to regulation by the Care Quality Commission (CQC). As a result, the responsibility for monitoring care standards rests with the employer with the support of direct payment scheme staff. Direct Payments recipients should be advised that the contracts they have with their own directly employed staff should include reference to the Kent and Medway Adult Protection Policy and Protocols. Staff directly employed should be made aware of adult protection issues by their employer and that any issues of abuse will be reported to social services and/or to the police. Local Authorities may place reasonable conditions on any agreement to make Direct Payments and conditions might be introduced to protect an individual with an identified vulnerability. Such conditions need to be proportionate to the risk involved and must not defeat the principal purpose of the direct payment, which is to give people more choice and control over services.

**A summary of changes to Direct Payments**

**What is changing?**

From 9 November 2009, important changes took place and the new regulations extended the Direct Payments scheme to people who lack the capacity to consent, and to people with mental health problems who are subject to mental health and certain criminal justice legislation.

**Direct Payments for adults lacking capacity to consent**

These changes mean that all councils must offer Direct Payments to certain eligible adults who lack the capacity to consent to receive Direct Payments and these can now be made to a willing and appropriate 'suitable person', such as a family member or friend, who receives and manages the payments on behalf of the person who lacks capacity.

**Direct Payments for people subject to mental health legislation**

Councils now have the same duty to offer Direct Payments to eligible people who are subject to mental health legislation as they do to anyone else in all but the following cases:

- People who are on conditional discharge from hospital under the Mental Health Act 1983 or the Mental Health (Care and Treatment) (Scotland) Act 2003, where councils will now have a power (but not a duty) to offer Direct Payments.

- In respect of a service which a person is obliged to accept as a condition of relevant legislation*, councils are not required to offer Direct Payments for that particular service – but have a power to do so. This includes conditions attached to guardianship, leave of absence from hospital or a community treatment order under the Mental Health Act 1983 and certain provisions in criminal justice legislation. (This means that councils now have a duty to offer Direct Payments to such a person in respect of a service which is not the subject of a condition if the person is eligible.)
People who are still excluded
People who are subject to drugs and alcohol-related provisions of some criminal justice legislation remain excluded from receiving Direct Payments. The legislation in question is listed in Schedule 1 of the new regulations.

Both KASS and Medway Council have developed their own Suitable Person Protocol that should be followed when considering the appointment of a suitable person when the outcome of a mental capacity assessment records that the person lacks the capacity to choose the direct payment option and where it is in their best interests to enable them to benefit from the flexibilities that Direct Payments offer.

Appointing a suitable person
Someone cannot just decide to be a suitable person in order to receive Direct Payments on behalf of another person. In most cases, the suitable person will be a family member or a close friend already involved in the provision of care for the person concerned. However, whatever the relationship of the proposed suitable person to the person requiring care, the council must still follow the process set out in The Community Care, Services for Carers and Children’s Services (Direct Payments) (England) Regulations (2009) to ensure that the best interests of the person lacking capacity are prioritised above all other considerations.

Before making Direct Payments for someone lacking capacity, the council must first obtain the consent of the suitable person who will receive Direct Payments on behalf of the person lacking capacity. In addition, where there is a surrogate of the person lacking capacity, the council must obtain the consent of that surrogate to make Direct Payments. Under the 2001 Act and the Regulations, a surrogate of a person is a donee of a lasting power of attorney created by that person or a deputy appointed by the Court of Protection who has been given powers relating to decisions about securing community care services to meet that person’s needs.

Unless the council establishes that the representative is either unwilling, incapable of managing Direct Payments or for some other reason inappropriate to act as a suitable person, by virtue of the powers already given to them to manage the affairs of the person lacking capacity, they would normally be the first choice of suitable person.

If the representative does not wish to act as a suitable person, the council should then look to see if there is an alternative person who would be willing to act as a suitable person. If the representative is also a surrogate, then they will need to consent to the appointment of someone else as a suitable person to manage the payments on behalf of the person who cannot consent. A surrogate is also a representative, that is to say a donee of lasting power of attorney or a court-appointed deputy. However, in order to be a surrogate rather than just a representative, the person's powers must cover decisions about securing services to meet a person's care needs. Lasting powers of attorney, for example, can cover a range of matters, including both personal welfare and property and affairs decisions, and may contain exclusions or restrictions.

Similarly, there may be specific circumstances in which a person other than the representative, in particular a close family member or a friend involved in the provision of care, is considered to be the most appropriate choice of suitable person by those consulted about making Direct Payments in respect of the person lacking capacity. If the council is satisfied that this arrangement would work in the best interests of the person lacking capacity, then it may, with the agreement of any existing surrogate, accept that individual as the suitable person, instead of the representative.

If there is neither a surrogate nor any other representative, then the council itself must make the decision about whether or not someone should act as a suitable person to manage the payments on behalf of the person who cannot consent.

In all cases, whether or not there is a surrogate to assist the council in its decision, and whether or not the proposed suitable person is a representative, the council should, so far as is reasonably practicable and appropriate, consult and take into account the views of the following people before making the decision to make Direct Payments to a suitable person:
• Anyone who has been named by the direct payment beneficiary before they lost capacity as someone to be consulted, either on the subject of Direct Payments to the suitable person, or related matters such as matters regarding their personal welfare.

• Anyone currently engaged in caring for the person lacking capacity to consent or anyone with an interest in their personal welfare.

• As far as is practicably possible, the person who lacks capacity themselves. Councils should ensure that they have taken all reasonable steps to ascertain the wishes of the person lacking capacity regarding who should act on their behalf. This includes consideration of any written statement of wishes and preferences made by the beneficiary before they lost capacity.

• Any representative or surrogate of the person lacking capacity. Generally speaking, an attorney or a deputy should always be consulted, even if they are not going to take on the role of suitable person. For instance, a professional person with a lasting power relating to a person’s property and affairs might still have information about the person’s wishes and feelings which should be taken into consideration when deciding whether someone is a suitable person to act on their behalf.

There may be occasions where it is in the best interests of the person lacking capacity to consent for their personal information to be revealed to the people consulted. Councils should ensure that social care staff who are trying to determine a person’s best interests act lawfully at all times, following their own professional guidance, as well as other relevant guidance concerning confidentiality. Legal advice should be sought where necessary.

**Conditions to be met by the suitable person**

As with all Direct Payments, the council must be satisfied that the beneficiary’s needs can be met by means of the Direct Payments and that the recipient (in this case the suitable person) is capable of managing the Direct Payments. To help ensure that the suitable person does not mismanage or misuse the Direct Payments, the Regulations set out a number of conditions that the council should require of the suitable person before it makes Direct Payments to that person on someone else’s behalf.

Unless the council is satisfied that it is necessary to satisfactorily meet the person’s needs, Direct Payments may not be used to secure services from the spouse, civil partner or partner of a person lacking capacity. Neither can they be used to secure services from a close relative, spouse or partner of a close relative of the person lacking capacity who is currently living in the same household as the person lacking capacity. There may be occasions when the council decides that it is necessary for the suitable person to use the Direct Payments to secure services from a member of the family of the person lacking capacity. However, such situations are likely to be exceptional and the council should be satisfied at all times that arrangements are made in the best interests of the person lacking capacity.

KASS and Medway Council have their own Exceptional Circumstance Procedures.

The suitable person manages the Direct Payments on behalf of the person lacking capacity, on the understanding that in doing so, they must act in the best interests of that person, within the meaning of the 2005 Act. This includes, as far as is reasonably practicable, encouraging and permitting the person lacking capacity to have the fullest input possible into decisions affecting them. The suitable person should be required to take all practical steps to ensure that decisions are taken in the best interests of the person who lacks capacity. This may involve consulting other people close to the person lacking capacity, or health and social care professionals where appropriate. To ensure that the service recipient can maintain as much control and independence as possible, the suitable person should be required to notify the council as soon as they believe the person has regained capacity.
Where disputes arise
The suitable person may face disagreements. KASS and Medway Council should refer to their own Suitable Person Protocol and the Direct Payment Guidance 2009 with others involved in or concerned for the welfare of the person lacking capacity to consent. Family members, partners and carers may disagree between themselves about how the Direct Payments should be spent, or they might have different memories about what views the person expressed in the past. Carers and family might disagree with a professional's view about the person's care or treatment needs.

The local council should support the suitable person to balance these concerns and decide between them. The council should include the person who lacks capacity (as much as they are able to take part) and anyone who has been involved in earlier discussions. It may or may not be possible to reach an agreement at a meeting to air everyone's concerns, but any decision must always be in the person's best interests, following the best interests principles in the 2005 Act.

Advocacy
An advocate may be useful in providing support for the person who lacks capacity to consent either in terms of deciding who should act as a suitable person on their behalf or, subsequent to that decision being made, how the Direct Payments should be used to meet their assessed needs. Advocates may be especially appropriate if:
- the person who lacks capacity has no close family or friends to take an interest in their welfare;
- family members disagree about the person's best interests;
- family members and professionals disagree about the person's best interests;
- the person who lacks capacity has already been in contact with an advocate; or
- there is a concern about the protection of a vulnerable adult.

Approaches to risk
The changes to the direct payment scheme brought about by the Health and Social Care Act 2008 were designed to enable adults lacking mental capacity to consent to Direct Payments to benefit from the choice and flexibility that Direct Payments can bring. People lacking mental capacity may not be able to exercise the same level of choice and control as other direct payment recipients. However, Direct Payments can still provide a vital means of ensuring that choices about the person's care and support can be made by those who are best placed to understand their needs and preferences and who know how to involve them as much as possible in decisions to support their best interests. However, councils should be very clear about the unique position of adults lacking capacity, who may not only be more vulnerable to abuse, but also less able to tell people when it is happening. Councils should therefore take steps to develop a comprehensive risk management strategy, which should inform the care plan and subsequent arrangements for monitoring and review. Application of a risk matrix determines the level of risk which in turn informs the frequency of reviews and whether they are carried out in person or otherwise eg. telephone, text, e-mail. Councils should consider involving other people known to the person lacking capacity, particularly those consulted when the suitable person was first appointed, as well as independent advocates where appropriate. The Mental Capacity Act Code of Practice specifies that Independent Mental Capacity Advocates (IMCAs) can be used in care reviews where the person concerned has no one else to be consulted.

Safeguarding
There are various legislative provisions that have been put in place to support safeguarding measures for adults lacking mental capacity. The Regulations specify that if the suitable person is not the spouse, civil partner, partner, close relative (or spouse or partner of a close relative) or friend involved in the provision of care of the person lacking capacity, then the council must obtain a CRB check for that suitable person, as a further protective measure for the person lacking capacity. For example, the suitable person may be an independent care broker or a solicitor acting as a professional deputy, who may not previously have been personally known to the service recipient.

Anyone caring for a person who lacks capacity for the purpose of the 2005 Act who wilfully neglects or ill-treats that person can be found guilty of a criminal offence under the Act punishable by up to five years in prison, or a fine, or both. In addition, the Fraud Act 2006 created a new offence of 'fraud by abuse of position'. This may apply to a range of people including attorneys under a lasting power of attorney (LPA) or enduring power of attorney (EPA) or deputies appointed by the Court of Protection to make financial decisions on behalf of a person who lacks capacity.
Someone acting as a suitable person receiving Direct Payments on behalf of someone lacking capacity to consent to the making of Direct Payments may be guilty of fraud if they dishonestly abuse their position, intend to benefit themselves or others, and cause loss or expose that person to the risk of loss. Without discouraging people from taking up the role of suitable person, councils should also make clear to anyone considering the role the consequences of financial misconduct or other forms of neglect or ill-treatment.

The Regulations also provide councils with the power to impose other conditions on the suitable person if they think fit. If councils believe that it is necessary to ensure the best interests of the person requiring services to impose other conditions, then this should be done.

**Direct Payments to people subject to mental health legislation**

KASS and Medway Council should refer the Direct Payment Guidance 2009

The following information identifies particular areas of risk and makes some suggestions about how these risks may be minimised.

### Direct Payments: Factors that increase the risk of abuse for vulnerable adults using Direct Payments Schemes, and how the risks may be minimised

<table>
<thead>
<tr>
<th>Area of risk</th>
<th>Description of risks</th>
<th>How to minimise the risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to the vulnerable adult’s home and personal telephone number by strangers</td>
<td>Vulnerable adults may be unable to protect themselves. The risk of abuse is likely to be increased through the recruitment and selection process, if this is carried out independently by the vulnerable adult. Non-bonafide strangers will have access to the vulnerable adult’s home and personal telephone numbers.</td>
<td>Direct Payments users are recommended not to carry out the recruitment and selection process from their home but to use a box number, dedicated telephone line for job applications and a room for the interviewing process, both of which, with sufficient notice, are available from Kent or Medway Social Services. Those who are unable or unwilling to use this facility are advised to be accompanied by a third party such as a friend, advocate, agent or Direct Payments support worker during the interviewing process. The Direct Payments support service advises service users to carefully scrutinise candidates’ details and references. Direct Payments users are informed that they can purchase services through home care agencies that vet their employees and are regulated by CQC.</td>
</tr>
<tr>
<td>Unfamiliarity with the recruitment and selection process</td>
<td>Vulnerable adults may have little understanding of recruitment, selection and employment procedures. This could potentially result in the unwise selection of personal assistants.</td>
<td>The Direct Payments support service provides guidance and support to service users regarding employment issues. This decreases the risk of unwise selection of personal assistants.</td>
</tr>
<tr>
<td>The lack of requirement for police checks through the Criminal Record Bureau</td>
<td>Care workers employed by vulnerable adults through the Direct Payments Scheme are not</td>
<td>Service users are encouraged to ask social services to carry out enhanced CRB checks for</td>
</tr>
</tbody>
</table>
## Area of risk

The requirements for Service Users that lack the capacity to choose the Direct Payment option.

- The lack of regulation

## Description of risks

- Required by law to be police checked through the Criminal Records Bureau. It is not possible for service users to undertake these checks themselves.

- A service user lacking capacity may be more vulnerable and less able to recognise or voice areas of concern.

- Care workers employed through Direct Payments Schemes are not subject to regulation by the CQC so there is no monitoring of care standards. This could increase the risk of abuse to the vulnerable adult during, for example, moving and handling operations, financial transactions or as a result of badly prepared or un-nutritious meals. Direct abuse has been experienced or is suspected.

## How to minimise the risks

- Personal assistants they have interviewed and wish to employ. Service users are strongly recommended to await the outcome of the CRB check, wherever possible before employing a personal assistant.

- If a Suitable Person is receiving a direct payment on behalf of someone else because they lack capacity, and they are not a family member or friend, then a CRB check in accordance with the Direct Payment Regulations 2009 MUST be carried out on anyone that they employ.

- When carrying out care plan reviews, care managers enquire about the standard of care of care workers employed under the Direct Payments scheme. Direct Payments users are given information regarding risk, both at the outset of the process and at reviews, so that they may make informed decisions. Reviews of finances are also undertaken by the care manager as part of the review process. Users should contact their care manager or direct payment support staff if they have any concerns about the quality of the care or how it is being provided. Users or other concerned adults have access to advice and support through social services in all cases where abuse is suspected.

## Links to further information:

DoH Guidance on Direct Payments For community care, services for carers and children’s services England 2009


The Community Care, Services for Carers and Children’s Services (Direct Payments) (England) Regulations 2009

Legal Issues Relating to the Abuse of Vulnerable Adults

The Social Care Institute for Excellence published in December 2011 ‘Safeguarding adults at risk of harm: A legal guide for practitioners’.

This guide is aimed primarily at practitioners working in various settings for organisations involved in safeguarding. But it may also be useful for volunteers and families. It aims to equip practitioners with information about how to assist and safeguard people. Knowing about the legal basis is fundamental, because the law defines the extent and limits of what can be done to help people and to enable people to keep themselves safe.

This guide is intended to serve as a pointer to the law and to how it can be used. It tries to explain the law in reasonably simple terms, so it is selective and does not set out full details of each area of law covered. When it comes to the law, further advice will often be needed, but an awareness of it can help practitioners ask the right sort of question and explore possible solutions.

To access the guide please see the SCIE website. This now replaces the whole of section 2. We suggest that you access this on line using the link above. Be aware that if you wish to print this document it has 280 pages. Although this is a sizable document it is very accessible with good contents pages that allows direct access to each section.
Indicators of Abuse

This section provides further information to assist in the identification of adult abuse. It should be read in conjunction with section 4 in the policy: Types of Abuse.

Indicators are the main signs and symptoms which suggest that some form of abuse may have taken place, but caution is suggested against establishing adult abuse merely due to the presence of one or more of these indicators without further detailed assessment/investigation. The following indicators of abuse are equally applicable in care homes, domestic homes, day centres, workplaces and other community settings.

Physical abuse indicators

i) A history of unexplained falls or minor injuries especially at different stages of healing.
ii) Unexplained bruising in well-protected areas of body e.g. inside of thighs or upper arms etc.
iii) Unexplained bruising or injuries of any sort.
iv) Burn marks of unusual type e.g. burns caused by cigarettes and rope burns etc.
v) History of frequent changing of General Practitioners or reluctance against General Practitioner consultation or visit.
vi) Accumulation of medicine which has been prescribed for the client but not administered.
vii) Malnutrition, ulcers, bed sores and being left in wet clothing.

Sexual abuse indicators

i) Unexplained changes in the demeanour and behaviour of the adult.
ii) Tendency to withdraw and spend time in isolation.
iii) Expression of explicit sexual behaviour and/or language by the vulnerable adult which is out of character.
iv) Irregular and disturbed sleep pattern.
v) Bruising or bleeding in the rectal or genital areas.
vii) Torn or stained underclothing especially with blood or semen.
vii) Sexually transmitted disease or pregnancy where individual cannot give consent to sexual acts.

Psychological abuse indicators

i. Inability to sleep or tendency to spend long periods in bed.
ii. Loss of appetite or overeating at inappropriate times.
iii. Anxiety, confusion or general resignation.
iv. Tendency towards social withdrawal and isolation.
v. Vulnerable adult appearing fearful and showing signs of loss of self esteem.
vi. The vulnerable adult uncharacteristically becoming manipulative, uncooperative and aggressive.

Financial abuse indicators

i. Unexplained inability to pay for household shopping or bills etc.
ii. Withdrawal of large sums of money which cannot be explained.
iii. Personal possessions go missing from home.
iv. Living conditions substandard and unsatisfactory in contrast to adult's apparent financial position.
v. Unusual and extraordinary interest and involvement by the family, carer, friend, stranger or door to door salesperson in vulnerable adult's assets.
Indicators of neglect

i. Inadequate heating, lighting, food or fluids.

ii. Poor physical condition of the vulnerable person e.g. ulcers, bed sores.

iii. Person's clothing and person appears to be unkempt.

iv. Failure to give prescribed medication or obtain appropriate medical care.

v. Apparently unexplained weight loss.

vi. Failure to provide appropriate privacy and dignity.

vii. Carers reluctant to accept contact from health or social care professionals.

viii. Refusal to arrange access to visitors.

ix. Inappropriate or inadequate clothing, or being kept in night clothes during the day.

x. Sensory deprivation, not allowed to have access to glasses, hearing aids etc.

xi. Vulnerable adult has no method of calling for assistance.

Discriminatory abuse indicators

i) Tendency to withdrawal and isolation.

ii) Fearfulness and anxiety.

iii) Being refused access to services or being excluded inappropriately.

iv) Loss of self esteem.

v) Resistance or refusal to access services that are required to meet need.

vi) Expressions of anger and frustration.

Institutional abuse indicators

The risk factors described in section 3 and indicators of abuse outlined above are equally applicable in an institutional setting whether managed by Kent County Council, Medway Council, private, health or a voluntary organisation. It is essential however, that differentiation is made between abuse which results from poor standards of care, lack of knowledge, understanding and training and specific allegations of abuse of one or more named service users by the service or by staff within a service. Depending upon the allegation and nature of the abuse, different interventions and action will be necessary by one or more agencies such as regulatory authorities, commissioning, health authorities, care management or police etc.

Patterns of abuse/abusing

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

- Serial abusing in which the perpetrator seeks out and ‘grooms’ vulnerable individuals. Sexual abuse usually falls into this pattern as do some forms of financial abuse.
- Long term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations.
• Opportunistic abuse such as theft occurring because money has been left around.

• Situational abuse which arises because pressures have built up and/or because of difficult or challenging behaviour.

• Neglect of a vulnerable adult’s needs because those around him or her are not able to be responsible for their care. This may be because the carer has difficulties attributable to issues such as debt, alcohol or mental health problems.

• Institutional abuse which features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and insufficient knowledge base within the service.

• Unacceptable ‘treatments’ or programmes which include sanctions or punishment such as withholding of food and drink, seclusion, unnecessary and unauthorised use of control and restraint or over-medication.

• Failure of agencies to ensure staff receive appropriate guidance on anti-racist and anti-discriminatory practice.

• Failure to access key services such as health care, dentistry, prostheses.

• Misappropriation of benefits and/or use of the vulnerable adult’s money by other members of the household or service providers.

• Fraud or intimidation in connection with wills, property or other assets.

Pre-disposing factors which may lead to adult abuse

The following factors may be relevant to any vulnerable adult whether living in a domestic home, care home or receiving care, support or services in hospital or any community setting:

• An unequal power relationship, whether physical, emotional or financial, generally exists between the abused and the abuser.

• Vulnerable adult with learning disabilities, mental health problems, or chronic progressive, disabling illness that create caring needs which exceed the carer’s ability to meet them.

• Adults living with other family members who are financially dependent on them.

• A personal or family history of violent behaviour, alcoholism, substance misuse or mental illness.

• The emotional and social isolation of the carer.

• Minimal or no communication between the dependent and the carer either through choice, incapacity or poor relationship.

• Financial difficulties often leading to substandard living conditions.

• Carers not in receipt of any practical and/or emotional support from other family members or professionals.
Responding to Initial Disclosures of Adult Abuse

Although staff are encouraged to be alert to the signs and signals which may indicate that someone in their care is being abused, many incidents will only come to light because the person discloses this themselves. The person to whom this disclosure is made will not necessarily be the person to take forward any investigation of the matter. If someone tells you about abuse, your role is to respond sensitively to the service user and pass the information on to your line manager or to a senior manager within your service, unless you suspect that they may be implicated in the alleged abuse. If you are concerned about their response or if you believe them to be implicated in the abuse, you should report your concerns directly to the social services agency or to the police.

Disclosure may take place many years after a traumatic event or when someone has left a setting in which they were afraid. This delay should not, in itself, cast doubt on its truthfulness.

If someone discloses abuse to you:

Do

✓ Stay calm and try not to show shock or disbelief.
✓ Listen carefully to what they are saying.
✓ Be sympathetic (‘I am sorry that this has happened to you’).
✓ Be aware of the possibility that medical evidence might be needed.
✓ Tell the person that:
  • They did the right thing to tell you.
  • You are treating the information seriously.
  • It was not their fault.
  • You are going to inform the appropriate person.
  • You/the service will take steps to protect and support them.
✓ Report to your line manager, senior manager or to the social services agency or the police.
✓ Write down what was said by the person disclosing as soon as possible.

And Do Not

x Press the person for more details. This will be done at a later date.
x Stop someone who is freely recalling significant events; (e.g. don’t say ‘Hold on we’ll come back to that later,’) as they may not tell you again.
x Ask leading questions that could be interpreted as putting words or suggestions to vulnerable adult or any vulnerable witnesses.
x Promise to keep secrets. You cannot keep this kind of information confidential.
x Make promises you cannot keep (such as, ‘This will never happen to you again’) 
x Contact the alleged abuser.
x Be judgmental (for example 'Why didn't you run away?')

x Pass on the information to anyone other than those with a legitimate 'need to know,' such as your line manager or other appropriate person.

At the first opportunity make a note of the disclosure and date and sign your record.

You should aim to:

- Note what was said, using the exact words and phrases spoken, wherever possible.
- Describe the circumstances in which the disclosure came about.
- Note the setting and anyone else who was there at the time.
- Separate out factual information from your own opinion.
- Use a pen or biro with black ink, so that the report can be photocopied.
- Be aware that your report may be required later as part of a legal action or disciplinary procedure.
The Line Managers Responsibility when Advised of an Initial Disclosure of Possible Abuse

If it is clear from the information available to you that there is a specific allegation of abuse, you must assess this information to decide what action you need to take. You may wish to consult with the social services agency to discuss these concerns to help you make this decision. Alternatively you may refer the matter directly to the social services agency or to the police for an investigation.

If it is not clear that abuse is an issue, you will need to obtain further information to assist you to determine what action to take.

Being clear about the concerns should enable you to take appropriate action. You need to ensure that any questions you ask of any vulnerable victims or witnesses do not compromise a possible criminal, or formal multi-agency investigation.

You should use open questions such as:

- 'Can you tell me what happened?'
- 'Can you tell me what was said?'
- 'Can you describe that to me?'

A criminal court may wish to know what questions you asked of a vulnerable person and their responses; so accurate written records are essential.

If you require advice or have doubts contact the social services agency or ring the police and ask for the combined safeguarding unit covering your location.
Guidelines to report adult protection concerns to the Social Services Agencies in Kent and Medway

These guidelines are designed to assist anyone who has a concern about a vulnerable adult who is or may be a victim of abuse. The protection of vulnerable adults is the moral responsibility of all those in contact with them in whatever capacity. If you are not sure if your concerns may be adult abuse, than you can contact the relevant Adult Social Services Agency in Kent or Medway for a consultation and advice.

No attempts should be made to question the alleged perpetrator, the vulnerable adult or other vulnerable witnesses other than to establish the basic facts and to confirm that abuse has or may have occurred.

Raising an alert begins the process of gathering information to decide if it is appropriate to deal with this as an adult protection referral. Contact should be made to the relevant Adult Social Services Agency where the alleged abuse happened (Kent or Medway). For a consultation or to raise an alert about your concerns, please contact either;

Kent Social Services on: 03000 41 11 11, between 08.30 – 17.00 hours

Medway Council Social Services on: 01634 334466, between 08.30 – 17.00 hours,

or for the Out of Hours Service for Kent and Medway, phone: 03000 41 91 91 to discuss/report your adult protection concerns.

Information for Statutory, Private and Voluntary Organisations:

All agencies/services involved in the care of vulnerable adults in Kent and/or Medway should have their own adult protection policy and procedures which are consistent with the Multi-agency Safeguarding Adults Policy, Protocols and Guidance for Kent and Medway. Concerns about adult abuse must be reported and recorded in line with the agency’s policy and procedures. These concerns may relate to the abuse of a vulnerable adult by anyone including another vulnerable adult. In all cases, the referrer should be prepared to provide information to support the adult protection process. If all of the information is not available, the referral should not be delayed. If the person(s) at risk is funded by another local authority, then that authority must also be informed. To make a referral please refer to Guidance section 7 for the Kent flowchart and Guidance section 7a for the Medway flowchart. The Kent AP1 alert form is Appendix 1 and the Medway AP1 alert form is Appendix 2 to this document.

For the Public:

If you are a member of the public you may wish to complete the relevant alert form AP1 with as much information as you can or you may telephone Kent Social Services on 03000 41 11 11 or Medway Social Services on 01634 334466 between 08.30 – 17.00 hours, or the out of hours service on 03000 41 91 91 to discuss/report your adult protection concerns.

The Social Service Agencies in Kent and Medway will work in partnership with other agencies, services and relevant people to address allegations of adult abuse.
Flowchart for reporting Adult Protection concerns to Kent Social Services

This section is to support anyone who works with or has contact with vulnerable adults to report their adult protection concerns to Kent Social Services where the alleged abuse has occurred in Kent.

**Abuse witnessed or suspected**

1. Ensure the immediate safety and welfare of the adult at risk and any other adults or children.

   1a. Is urgent medical attention required? Call 999

   1b. Is urgent police attention presence required? Call 999

2. If you believe a crime may have been committed report your concerns to the police dialing 101. Please be aware of the need to preserve any forensic evidence.

3. If you work in a service discuss your concerns with your line manager. If you believe that your line manager/service may be implicated in the suspected abuse you may consult the Police, the Social Services Agency or the Regulatory Authorities and discuss your concerns with them.

4. Decide on whether to raise an adult protection alert by gathering only essential information necessary to report your concerns to Kent Social Services using the AP1 alert form or you may wish to consult with them initially by phoning 03000 41 11 11 between 8.30 and 5 pm, or out of hours 03000 41 91 91.

5. If the person does not consent to the referral, are there justifiable reasons to act contrary to their best wishes?
   - Risks to other vulnerable adults or children?
   - The allegation relates to the conduct of an employee or volunteer within an organisation providing services to a vulnerable adult?
   - The mental capacity of the person to decide?
   - Inability to consent due to undue influence or intimidation?
   - The serious harm occurring?

6. The social services agency will acknowledge receipt of form AP1 and will assess the information and decide upon the most appropriate response to the concerns.
If you have concerns that an issue reported to the Kent Social Services agency has not been appropriately addressed you should contact Kent’s Central Duty Team on:

**CentralDutyTeam@kent.gcsx.gov.uk** (Secure e-mail*)

**Central.duty@kent.gov.uk** (Standard e-mail)

Or by phone on **03000 41 11 11**

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7. The social services agency will advise the referrer how their concerns will be addressed. The referrer must advise the social services agency of any changes to the service user’s situation.

8. Whenever possible the social services agency will work in partnership with all agencies and services to address allegations of adult abuse. This will include where appropriate informing the regulatory body and the relevant commissioning department(s) if the referrer has not already done so.
Flowchart for Abuse Witnessed or Suspected that has occurred in Medway

Within an organisation, an employee or volunteer must alert their line manager or designated officer to any safeguarding adult concerns or allegations.

You are alerted by a member of staff or become aware that abuse or neglect has occurred or is suspected

1. Ensure the immediate safety and welfare of the adult at risk (and from any other person at risk)

1a. Is urgent medical attention required? Call 999

1b. Is urgent police attention presence required? Call 999

2. Does a crime need to be reported? Be aware of the possible need to preserve forensic evidence. Call 101 (non-emergencies). If life is in danger or crime is in progress call 999

3. Decide on whether to make an adult protection alert by gathering only information you need to raise the alert. If you are not sure whether to raise an alert, CONSULT with Medway Council Adult Social Care Team (see contact details). If the person does not consent to the information being shared, are there justifiable reasons to act contrary to their best wishes?

- Risks to other vulnerable adults or children?
- The allegation relates to the conduct of an employee or volunteer within an organisation providing services to a vulnerable adult?
- The mental capacity of the person to decide?
- Inability to consent due to undue influence or intimidation?
- The serious harm occurring?

4. Make an adult protection referral

4a. Statutory Organisations – please complete part A of the CM31 form (available on your internal systems)

4b. Private & Voluntary Organisations – please complete AP1 form (see Appendix 2)
A referral begins a process of gathering facts, assessment of the allegation, assessment of the vulnerable adult's needs and a risk assessment to decide whether the Multiagency Safeguarding Adults policy applies.

Contact details Medway Council Adult Social Care:

**Telephone:** During working hours (01634) 334466 or out of hours service 03000 41 91 91.

**Fax:** During working hours (01634) 334504 or out of hours service (01233) 646596.

**Secure Email:** During work hours: ss.accessandinfo@medway.gov.uk cjsm.net

NB. Before sending any referrals by Fax or Email please telephone first to advise.

To access an electronic version of the AP1 form, see Appendix 2 or follow this link: http://www.medway.gov.uk/abuse
Adult protection guidance

To help providers understand what might happen after an adult protection concern/alert is raised.

Adult protection concern raised involving vulnerable adults in care settings or receiving care from a domiciliary care service

Adult protection consultation and/or planning/strategy meeting takes place, led by the social services agency

Multi agency professional representatives invited; referrer and or service provider may be invited to all or part of the planning/strategy meeting.

Decision made about Actions-Investigation and/or Assessment

Level of risk agreed

Service provider advised of agreed actions

These may include:

a Investigation
If police involved, criminal investigation takes precedence. Investigations or assessment by SSD, health, contracts, regulators may then take place or run concurrently. Employers should be cognisant of their responsibilities under employment law but should avoid compromising the criminal/formal investigation of the adult protection concerns. Providers are advised to discuss any actions they propose to take with the investigating officer.

b Assessment
Scope of alleged abuse and impact on service users.

c Related risk assessment
Actions taken to address identified risks and further risk assessment as agreed. Is referral to ISA required? Service provider notified of any warning flag placed on the appropriate contracts database related to their service and of the associated risk level.

Adult protection review meeting(s) and/or case conference

Feedback of the outcome of investigation/assessment.

Level of risk reviewed and any further action agreed/recommended.

Post abuse care plan for service user(s) agreed. A separate meeting will also need to address any identified needs of vulnerable perpetrator(s)

Registered manager and other service managers may be invited to an Establishment Case Conference focussing on service issues.

Outcome of the investigation/assessments explained and decision regarding the need for any further action(s) to take place.

Post abuse action plan agreed for the service where necessary.

Decision taken re: Status of alert (open/closed) Relevant people advised of the outcome of the investigation/assessment if concluded.

Monitoring and review of the post abuse action plan for the service provider carried out by identified agencies/personnel.
Guidance for agencies addressing adult protection concerns for d/Deaf people

This guidance has been developed to assist in the management of adult protection concerns where d/Deaf service users are involved.

The aim of the guidance is to ensure that all agencies and their staff understand how to obtain appropriate expertise and communication services for a wide range of d/Deaf adults, when concerns about abuse are raised.

The term d/Deaf is used to differentiate between 'd' people who may be described as partially deaf or hard of hearing; 'D' people who can be described as a cultural and linguistic minority group.

1 An adult abuse concern is referred to the social services agency involving a d/Deaf adult(s). The d/Deaf individual(s) may be a:
   - Victim(s),
   - Witness(es) or
   - Alleged Perpetrator(s).

   a If the d/Deaf individual is the victim, then this is an adult protection issue and must follow the normal referral process for adult protection. The support of the Deaf Services Bureau must be requested as in item 3.

   b If the d/Deaf individual is a witness then the matter should be referred directly to the Deaf Services Bureau (DSB) who will provide advice and assistance as necessary to the individual and/or the police. This is not adult protection.

   c If the d/Deaf individual is the alleged perpetrator then the police may ask for assistance in dealing with the case. The matter should be passed directly to the Deaf Services Bureau. This is not adult protection. If the alleged perpetrator is under 18 then the local child protection team should be informed of the case.

2 Referrals for adult protection are normally addressed by the social service agency office that is nearest to the victim’s place of residence. If the victim has a care manager/social worker the referral may be made directly to them. In Kent the initial call may be routed through the county duty service. In Medway the call may be routed through their duty service. They will pass the caller to the appropriate local office or take some basic details of the referral and pass the information to the local office by telephone and e-mail.

3 The locality office must inform the relevant DSB team immediately of the alert (See useful addresses section at the back of this guidance). Their role is to co-work and to provide specialist input with regard to deaf people's cultural and communication issues. (See the role of the DSB social worker in adult protection).

4 If the concerns may also be criminal then the police should also be contacted immediately by the designated senior officer or their representative.

5 The planning process must be started immediately. This should be led by a designated senior officer from adult services or mental health services. The DSB must be involved in any decisions taken regarding emergency actions or any other actions indicated. It is advised that a formal planning/strategy meeting should be called as soon as possible. Normally within 48 hours of the receipt of the alert.
6 The DSB must be involved in assessing the communication and any cultural needs of the d/Deaf individuals involved as a matter of urgency. The DSB will carry out the assessment(s) either by communication with formal or informal carers, other professionals or by face to face meeting(s) with the individual(s) concerned.

7 The DSB must make a written record of the communication and any cultural needs to inform the investigation/interview process. This should make clear the type of communication support required and who should provide it. This may include the use of relay interpreters where necessary. (See the role of the relay interpreter).

8 If the case is likely to be a criminal matter the police are responsible for arranging and paying for appropriate interpreters for the purposes of the investigation. Where additional interpreters are required for court proceedings and/or for defence purposes the responsibility for obtaining and paying for these interpreters lies with the court or the defence respectively.

9 An Early Special Measures meeting between the Police and the CPS may be required to ensure that appropriate steps are taken to maximise the individual's ability to provide their evidence to the court. The assessment of the individual's communication and cultural needs will inform the decision-making process.

10 If, from the information available, the concerns do not appear to be of a criminal nature, then the DSB are responsible for arranging appropriate interpreters for the investigation process to be carried out by the social services agency and any other agency. DSB staff should not be asked to act as interpreters.

11 Prior to any formal interview (criminal or non-criminal) with a d/Deaf person, there will be a need to clarify the roles of the respective practitioners/carers within the process.

12 DSB staff will be involved in the interview processes to ensure that the communication needs of the d/Deaf user(s) are appropriately addressed.

The role of the deaf services bureau social worker in adult protection

The DSB will be involved in adult protection matters on a consultative basis with any department involved in an adult protection issue concerning a d/Deaf person.

The DSB may also be involved in casework regarding any alleged perpetrator, victim or witness in the course of their business.

The role of the relay interpreter

The term relay interpreting is used when more than one interpreter is needed to assist communication. This technique is used whenever the service user does not understand interpreting or the interpreter has difficulty understanding the voice or the signing of the service user. The reasons for using relay interpreting include:

- The service user has lost vision recently, can no longer rely on visual sign language and is uncomfortable with tactile sign language but understands a relative or friend.
- The service user has a neurological condition that makes the sign language or speech deviate from normal.
- The service user needs the support or presence of a family member or carer who may be involved in part of the interpreting although some of the interpreting usually goes directly via the interpreter.
- The service user has minimal language skills and needs an interpreter who knows his/her limited vocabulary.
It is common practice for the second person helping in the communication to be a family member, teacher or social care worker. However, even if this person is a British Sign Language (BSL) user, they should not function as the only interpreter. They usually function as advocates which is a different role than that of an interpreter.

When relay interpreting is used, the duration of the meeting/appointment will be significantly increased. It is possible that some information may be lost. Both the interpreter and the other professionals have to be very alert and sensitive and help the relay person rephrase questions using simple, more common concepts if the service user does not seem to understand.

The contents of this protocol will need to be included in the adult protection awareness and alerters training and will need to be considered in any joint investigation/interviewing training.
Adult Protection Flowchart
For cases involving d/Deaf service users.

An adult protection alert is received by social services for a victim who is d/Deaf.

Immediate contact to be made to the Deaf Services Bureau to facilitate Communication Assessment.

Is this likely to be a Criminal Matter?

- YES
  - Multi-agency planning/strategy meeting held. Terms of reference for investigation/assessment agreed.
  - The service provider may be included in all or part of the planning process.
  - They must however be informed of actions proposed as soon as practicably possible.

  **Agreed Actions May Include:**

  a) **Investigation**
     - If police involved, criminal investigation takes precedence. Investigations or assessment by SSD, health, contracts, regulators may then take place or run concurrently. Employers should be cognisant of their responsibilities under employment law but should avoid compromising the criminal/formal investigation of the adult protection concerns. Providers are advised to discuss any actions they propose to take with the investigating officer.

   b) **Assessment**
      - Scope of alleged abuse and impact on service users.

   c) **Related Risk Assessment**
      - Actions taken to address identified risks and further risk assessment as agreed. Is referral to POVA required? Service provider notified of any warning flag placed on the appropriate contracts database related to their service and of the associated risk level.

- NO
  - Interpreter required for police interview. Police to engage interpreter using information from DSB and any relevant information regarding the victim’s communication needs and information regarding cognitive ability.

  - Interpreter required for alternative interview. DSB to make contact with RNID. Interpreting service using their assessment of the victim’s communication needs and information regarding cognitive ability.

  Multi-agency planning/strategy meeting held. Terms of reference for investigation/assessment agreed.

  The service provider may be included in all or part of the planning process.

  They must however be informed of actions proposed as soon as practicably possible.

  **Agreed Actions May Include:**

  a) **Investigation**
     - If police involved, criminal investigation takes precedence. Investigations or assessment by SSD, health, contracts, regulators may then take place or run concurrently. Employers should be cognisant of their responsibilities under employment law but should avoid compromising the criminal/formal investigation of the adult protection concerns. Providers are advised to discuss any actions they propose to take with the investigating officer.

  b) **Assessment**
      - Scope of alleged abuse and impact on service users.

  c) **Related Risk Assessment**
      - Actions taken to address identified risks and further risk assessment as agreed. Is referral to POVA required? Service provider notified of any warning flag placed on the appropriate contracts database related to their service and of the associated risk level.

  Investigation/assessment completed

  **Case conference called**

  If vulnerable adult(s) were implicated as perpetrators, post abuse care plans to be agreed in a separate section of the Conference.

  **Establishment case conference or review meeting involving the service provider**
  (If service implications were identified)
  - Meeting with registered manager and any other service managers.
  - Outcome of the investigation/assessments explained. Post abuse action plan agreed.

  **Monitoring and review of post abuse plans to be carried out by identified agencies and personnel**

  All relevant people advised of the outcome of the alert.
Consent and Mental Capacity

The content of this section is informed by:
View MCA Code of Practice
View MCA Summary
View MCA Easy Read Summary

In law, every adult has the right to make their own decisions and is assumed to have capacity to do so unless it is proved that they do not. All adults have a right to determine what happens to their own bodies and (if they are able to give it) valid consent must be obtained from them before providing personal care, such as bathing and dressing.

When carrying out an adult protection investigation/assessment it is important to respect the right of vulnerable adults to make decisions with regard to their own safety. They should therefore be encouraged to make decisions that they are able to make. Difficulties arise when it is not clear whether the vulnerable adult is capable of making a decision or whether the decision is being made under duress.

Mental Capacity refers to the capacity to understand and retain the information in relation to a specific act, decision or transaction, to weigh up their consequences and to communicate the decision, at the time the decision needs to be made.

a There is no universally accepted definition of mental capacity and the assessment of capacity.

b Different levels of mental capacity are necessary for different types of decisions. A vulnerable adult suffering from a mental disorder is not necessarily incapable of giving consent.

c Mental capacity should always be assessed in relation to the specific issue and context that is being considered.

d It is important to assess whether the vulnerable adult is capable of making the particular decision that is required at that point in time.

e This will recognise that a vulnerable adult's mental capacity may change (may be regained or developed with support) over a period of time and/or they may have a condition that leads to fluctuations in mental capacity.

Consent. For a vulnerable adult to give consent they should be able to understand and retain relevant information that is being given to them, believe it to be true and weighing it in the balance, be able to make a choice.

Within the adult protection process it is always important to consider whether a vulnerable adult is capable of giving their consent.

This may be in relation to whether they gave consent to:

- The activity that is deemed to constitute an abusive act.
- Whether the adult protection investigation/assessment should go ahead.
- Whether certain decisions or actions should be taken during the process of an adult protection case.
- Whether the recommendations set out in the adult protection plan should be put into place.
It will be important to make a decision about the consent issue with regard to addressing the alleged abuse. An assessment should be made about how much a person understands and how far they are able to make a decision. It will be necessary to consider if:

- The vulnerable adult did give consent to any action that was taken.
- The vulnerable adult is capable of giving consent i.e. do they understand what they have given consent to?
- Their apparent consent should be disregarded if it was given under duress as a result of exploitation, intimidation, undue pressure or fear of reprisal. Consent given under such conditions is not legally binding.
- In law most adults are deemed to have capacity to make decisions. Exceptions to this are:
  - Vulnerable adults with severe learning disabilities who are not deemed to be able to give consent to sexual acts.
  - Vulnerable adults who have already been assessed as incapable of managing their own finances. e.g. Their finances are subject to the Court of Protection.
  - Vulnerable adults who are subject to certain orders under current mental health legislation.

Where there is any doubt about a vulnerable adult's mental capacity and/or their ability to consent it is important to have an appropriate medical/social assessment carried out.

Due to the fact that social workers were not listed on the Court of Protection COP3 (Assessment of Mental Capacity) form as someone allowed to carry out the capacity assessment, some judges within the Court of Protection had been unprepared to accept an assessment carried out by a social worker, requiring it to be completed by a medical practitioner instead. In November 2013, following a review of the COP3 Form, the Court of Protection has now agreed that they will accept the mental capacity assessments carried out by a social worker.

When a vulnerable adult with capacity has made a decision that they do not want action taken to address any abuse they are being subjected to, this will be respected unless failure to act will leave other vulnerable adults or children at risk.

Consent to medical examination in the context of a possible criminal offence:

A medical examination may be considered for two reasons:

- Medical treatment may be required
- The examination may provide evidence that could be used in a prosecution.

When urgent medical attention is required following a physical or sexual assault this will normally precede any other actions.

If the vulnerable adult is considered to have mental capacity, their consent should be obtained before a medical examination for forensic purposes is carried out.

If there is any possibility that forensic evidence can be found the vulnerable adult's permission should be sought regarding police involvement.

If it is considered that the vulnerable adult does not have mental capacity at the time, a decision must be made which reflects the best interests of the person and the wider public.

Practice matters:
a Where a medical examination is indicated the issues should be explained in a way that gives the vulnerable adult the best opportunity for understanding it.

b Communication issues must be considered where English is not the vulnerable adult's first language or where physical or sensory impairment or learning disabilities make communication difficult.

c If there are concerns about the mental capacity of a vulnerable adult or an alleged perpetrator, an assessment of mental capacity should be carried out as part of the investigation.

d Unless there is evidence of a recent assessment a referral should be made to the appropriate health professionals. The assessment can then be used to inform the post abuse protection/service plan.

e If police need to carry out an interview with a vulnerable adult, the process should be managed under Achieving Best Evidence principles.

f It may be necessary to ensure that the vulnerable adult is offered legal advice and/or an independent advocate.

g Where it is established that a vulnerable adult has mental capacity to make informed decisions and they choose to place themselves at further risk of abuse, they should be made aware of the possible outcomes of their decision.

h They should be offered a range of options that they may wish to pursue either now or in the future. They should always be left with information that would allow them to access help and advice in the future.

If the vulnerable adult lacks or is believed to lack capacity to make decisions with regard to keeping themselves safe consideration should be given to involving relatives advocates or an IMCA to support the client through the adult protection processes.
The Principle of Best Interests and Duty of Care

In some situations, in order to protect the vulnerable adult or other vulnerable adults or children from abuse or possible abuse, it may be necessary to take decisions on their behalf. In taking these decisions it is important that the person taking the decision is acting in the best interests of the vulnerable adult and with due regard to their duty of care. In doing so they will:

a  Act in a way that is necessary to promote the vulnerable adult's health or well being or to prevent deterioration in their quality of life.

b  Avoid discrimination and do not make assumptions about the vulnerable adult's best interests simply on the basis of the person's age, appearance, condition or behaviour.

c  Ensure that the intervention is as least restrictive as possible to maintain the safety of the vulnerable adult.

d  Ensure that any decision is made with proper regard for the due process of law.

e  Ensure that the ascertainable past and present wishes and feelings, beliefs and values of the vulnerable adult concerned are taken into account.

f  Ensure that the vulnerable adult is encouraged and supported to participate in any decision made which affects him or her.

g  Need to be satisfied that the expressed wishes of the person without capacity were not made as the result of undue influence.

h  Consider any other factors the vulnerable person would be likely to consider if they were making the decision or acting for themselves.

i  If it is practical and appropriate to do so, consult other people for their views about the person's best interests.

An Independent Mental Capacity Advocate (IMCA) identified within the Mental Capacity Act 2005 must be instructed for people lacking capacity who have no one else who 'it would be appropriate to consult' (other than paid staff) whenever:

- An NHS body is proposing to provide serious medical treatment
- An NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home and the person will stay in hospital longer than 28 days or in the care home longer than 8 weeks.

An IMCA may be instructed, subject to individual case discussion with the relevant commissioning Local Authority, to support someone who lacks capacity to make decisions concerning

- Care reviews when no one else is available to be consulted
- Adult protection cases, whether or not family, friends or others are involved

For additional information regarding the IMCA Service see: View IMCA Booklet
Learning Difficulties/Disabilities and Vulnerable Adults with Cognitive and Communication Difficulties/Disabilities

Good practice when an adult protection investigation/assessment involves a vulnerable adult with learning difficulties/disabilities or any cognitive and communication difficulties/disabilities.

1. The particular needs of the person must be taken into account when planning an adult protection investigation.

2. Recognising abuse of people with learning difficulties/disabilities may be difficult due to communication problems and the likelihood that alternative explanations may be given for their behaviour.

3. A range of people who know the individual should inform the involvement with the vulnerable adult during the investigation.

4. Particular care should be taken to ensure that the individual's communication needs are addressed. Speech and language specialist assessment may be indicated where the individual's communication and comprehension of language is not clear.

5. Support needs to be in place for the individual, their carers and support staff throughout and following the adult protection investigation.

6. The person with learning difficulties/disabilities should be enabled to make informed choices about their participation in the adult protection process. They should receive appropriate information and support during the interview process.

7. Interviews need to be planned to take into account the vulnerable adult’s method of communication and individual need. It is important to plan the style of questioning to be used.

8. The development of an adult protection care plan should give due regard to any therapeutic services or additional support that is needed by the vulnerable adult.
Whistleblowing (Public Interest Disclosure Act 1998)

Whistleblowing is the term given to a situation where a member of staff or a volunteer reports a concern about something that is happening in their workplace. This may be with regard to fraud, health and safety issues, abuse or the standard of care provided to a vulnerable adult or child.

1. The concern may be reported to the line manager within the organisation or it may be reported to a more senior manager or to an external body.

2. Some organisations have a whistleblowing procedure with a designated officer who will deal with complaints from staff about their concerns about what is happening in the workplace.

3. It can be very difficult for a person who acts as a whistleblower with respect to their relationships with other members of staff and their employers. They may be very fearful for their future employment prospects.

4. A member of staff may report concerns about abuse or suspected abuse of a vulnerable adult directly to the duty officer at the office of the social services agency nearest to the home of the vulnerable adult.

5. The person ‘blowing the whistle’ may be reluctant to give their name or they may ask that they remain anonymous. Their wishes will be recorded and respected as part of the referral process. Whilst respecting their right to confidentiality, they cannot however be given an absolute undertaking that they will not be identified at a later date, especially if any legal action is indicated.

6. In the case of a serious crime being reported, the referrer will be informed that the matter needs to be reported to the police.

7. If the person ‘blowing the whistle’ chooses to go through an intermediary, that person has a duty to report the abuse of a vulnerable adult to the duty officer of the social services agency, or to the police if they consider that a criminal offence may have been committed.

From 1 January 2012, the Government-funded whistleblowing helpline became a free-phone service provided by the Royal Mencap Society, to provide free, independent and confidential whistleblowing advice.

The helpline will operate weekdays between 08:00-18:00 with an out of hours answering service available weekends and public holidays and is available to all health and social care staff. A web-based service is also being developed.

If you have concerns but are unsure how to raise them or simply want advice on best practice, from 1 January 2012 you can call free on: 08000 724 725.
Staff Disciplinary Procedures

1. Organisations providing health and/or social care services to vulnerable adults must have their own staff disciplinary procedures.

2. If a manager in such an organisation is aware that a member of staff is abusing or suspected of abusing a vulnerable adult, they should use their internal staff disciplinary procedures to take action to protect vulnerable adults/children from the risk of abuse.

3. If it appears that a criminal offence has been committed then the police should be informed as a matter of urgency.

4. The employer should report their adult protection concerns to the local social services office/mental health trust office and advise what actions they have taken to protect vulnerable adults/children from the risk of abuse.

5. If it appears that an investigation is necessary then police or the social services agency should co-ordinate the response.

6. The employer should ensure that they comply with employment legislation at all times.

7. The employer may await the outcome of any external investigation before taking any disciplinary action. They may however carry out their own internal inquiry into the issues raised provided this does not interfere with any criminal investigation.

8. If the matter is being dealt with as a formal police or social services led adult protection investigation, the employer should be advised not to interview vulnerable victims/witnesses until the formal investigation has been completed.

9. Managers of a service that is registered under the Health and Social Care Act 2008 must inform the appropriate office of the Regulatory Authority.
Working with the Police

The Early Involvement of the Police may have benefits (see protocol 16), in particular:

- early involvement of the police will help to ensure that evidence is not lost or contaminated;
- early referral or consultation with the police will enable them to establish whether a criminal act has been committed and this will give them the opportunity of determining if and at what stage, they need to become involved;
- a higher standard of proof is required in criminal proceedings than in disciplinary or regulatory proceedings (where the test is the balance of probability);
- police officers have considerable skill in investigating and interviewing and their early involvement may prevent the abused adult being interviewed unnecessarily on subsequent occasions;
- police investigations should proceed alongside those dealing with health and social care issues.

The most serious offences can emerge from uncertain and unclear circumstances. Sometimes gathering reliable evidence can require swift unannounced action. Protection options can increase in proportion to the availability of reliable evidence and information. Inappropriately alerting dangerous carers can leave vulnerable people unprotected and at risk.

Professionals have to consider seeking consent for certain actions and information sharing. Professionals need to be aware of the Data Protection Act and crime prevention exemptions. They need to be able to consider the rights of individuals under the Human Rights Act. Professionals should have access to the multi-agency adult protection policy for Kent and Medway.

The following section may assist in deciding what actions may be indicated.

Physical abuse

Physical abuse is usually associated with hitting and injury. Injuries can have innocent explanations and the utmost discretion and sensitivity must be used where suspicions are aroused.

Where injuries are apparent, close inspection is required. Being able to describe an injury in terms of colour, size, depth and shape is important. This description should be recorded and kept. Body maps are a useful tool in this regard. Some medical conditions can present as injuries. Medical advice may be required. Explanation from the person with the injury is crucial, where it is not forthcoming it should be asked for with a simple open question e.g. ‘What happened here?’

This must be asked away from inappropriate influence. Where communication is not possible, enquiries with others may need to be made to establish the cause. As soon as suspicion arises that the cause may be deliberate or a careless action of another then the police should be informed.

Any explanation can be compared with the circumstances of the individual and the nature of the injury, this can inform decision-making. Careful records should be kept.

Marks or injuries indicating the use of weapons e.g. marks resembling imprints, burns or bite marks should be treated seriously. Professionals should be alert to common signs of abuse. Individuals who make allegations should be listened to and taken seriously.
Sexual abuse

Sexual abuse often manifests itself in unusual behaviours but no behaviour is definitive of sexual abuse. Discussion within your agency/service together with referral and information sharing between agencies, dependent on levels of suspicion, can inform appropriate action. Any indication of a possible sexual offence occurring within the last few days should be referred to the police immediately.

Where allegations of sexual crimes are made, how the allegation came about, exactly what was said and the demeanour of the person making the allegation should be recorded and immediately referred to the police. Consideration must be given to the vulnerable adult's mental capacity and to the question of what action is in their best interest. A factor that needs to be considered is whether any other vulnerable adults or children may be at risk.

Ill-treatment or wilful neglect

The Mental Capacity Act 2005 introduces two new criminal offences: ill treatment and wilful neglect of a person who lacks capacity to make relevant decision (section 44). The offences may apply to:

- Anyone caring for a person who lacks capacity – this includes family carer, healthcare and social care staff in hospitals or care homes and those providing care in a person’s home
- An attorney appointed under a Lasting Power of Attorney (LPA or an Enduring Power of Attorney (EPA), or
- A deputy appointed for the person by the Court of Protection.

These people may be guilty of an offence if they ill-treat or wilfully neglect the person they care for or represent. Penalties will range from a fine to a sentence of imprisonment of up to five years or both.

**Ill treatment and neglect** are separate offences. For a person to be found guilty of ill treatment, they must either:

- Have deliberately ill-treated the person, or
- Be reckless in the way they were ill-treating the person or not.

It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

The meaning of 'wilful neglect' varies depending on the circumstances. But it usually means that a person has deliberately failed to carry out an act that they knew they had a duty to do.

Wilful bullying or behaviour likely to engender fear may amount to ill-treatment.

Carers of vulnerable people who wilfully fail to provide adequate food, clothing, medical aid or accommodation for them may be guilty of this offence. Signs to watch for include; failing to thrive, personal hygiene issues, always being hungry, being in fear, hazards within the home and being left alone. The most serious offences may come about in circumstances of neglect. Sometimes these situations can only be properly recorded and evidenced by police exercising their powers to investigate crime. The police should always be informed where serious neglect is likely to cause suffering.

Psychological/emotional

Psychological abuse can amount to ill-treatment under The Mental Health Act 1983. Emotional abuse can amount to criminal assault.

Witnessed incidents of verbal abuse may be a culmination of pressures on families or carers and if considered in isolation may be misleading. Unless incidents are severe or amount to crimes of assault or ill-treatment, a sensitive approach should be made.
Consent of the vulnerable adult

In all cases staff should attempt to obtain the consent of an individual before calling the Police. This is not always appropriate and the requirement to obtain consent may be overridden or dispensed with depending on the following points:

- The seriousness of the incident.
- The risk to other people.

The capacity of the individual to make the decision.

When an individual declines contact with the police, an assessment as to what would be in the best interests of that individual or other vulnerable adults or children should be made and recorded.

Calling the police in an emergency

When dealing with an incident that involves the abuse of a vulnerable adult, staff should call the police (dial 999) immediately if:

1. There is serious risk of significant harm occurring.
2. There is likely to be evidence that needs to be preserved.
3. In the case of a physical or sexual assault the police will be able to arrange for medical evidence to be collected.
4. It is believed that a recent sexual assault has taken place.
5. Someone has been injured as a result of a physical assault.
6. An allegation is made regarding a recent incident of theft.
7. The alleged perpetrator needs to be removed.
8. The alleged perpetrator is still believed to be near the premises.
9. There is reason to believe that a crime is in progress.

If you are unsure what to do, it is advisable to call the police. The police officers attending the incident will decide if a crime has been committed and whether their intervention is appropriate.

Preserving evidence

When dealing with any allegation of abuse, due regard should be given as to whether the police should be involved and whether it is necessary to preserve evidence relating to the incident.

Consider the following:

- The well being of the victim must be your first priority.
- When the police are involved following an alleged crime, they are likely to respond quickly.
- To enable the police to investigate effectively it is crucial that evidence is preserved. If in doubt consult the police on the telephone prior to their arrival.
- What is done or not done, in the time prior to police arriving on the scene, may make all the difference to their investigation.
- When dealing with allegations of financial abuse or other irregularities, documentation should not be removed or altered in any way.
Practical guidelines

The following points may help you preserve evidence:

1. Secure the scene and do not allow anyone to enter until the police arrive, with the exception of medical staff if the victim requires medical attention.

2. Obtain consent before examining the victim.

3. Examination should only be necessary to determine the extent of injury, provide first aid or arrange for transfer to hospital.

4. Ensure that the victim and the alleged perpetrator do not come into contact with each other once the allegation has been made. This should prevent any cross contamination of evidence.

5. Remember that the welfare of the alleged victim is paramount and you will not be held accountable if you inadvertently destroy or invalidate evidence.

6. Where possible, leave things as they are. If anything has to be handled, keep this to a minimum. Do not clean up. Do not touch anything you do not have to.

7. Leave weapons where they are unless they are handed to you. If a weapon is handed to you, take care not to destroy fingerprints.

8. Do not wash anything or in any way remove blood, fibres etc.

9. Preserve the clothing and footwear of the victim. Handle them as little as possible.

10. Note in writing the state of the clothing of both the alleged victim and the alleged perpetrator. Note injuries in writing. Make full written notes on the conditions and attitudes of the people involved in the incident. This should be done as soon as practicably possible.

11. Note and preserve any obvious evidence such as footprints or fingerprints or any other evidence, which may have been left behind by the suspect.

12. Preserve any video tape if security cameras are present.

Cross contamination

Whenever two objects meet there is an exchange of material from each to the other. In other words every contact leaves a trace.

Evidence in cases of sexual abuse

The following should be considered in cases of sexual abuse:

1. In serious cases, an examination of the victim by an appropriately trained forensic medical examiner will need to take place, if permission is granted.

2. An examination of the alleged perpetrator should also be carried out after arrest.

3. Try not to have any person in physical contact with both the victim or the alleged perpetrator as cross-contamination can destroy evidence.

4. Preserve bedding where appropriate and any items that might contain evidence e.g. used condoms.
5 In any instance where a victim is seriously injured and is taken to hospital, the police should ask for a sample of blood to be taken before any transfusion is given, as a transfusion will invalidate evidence in relation to blood.

6 Health care staff should endeavour to work in conjunction with the police at the scene and to cooperate with the investigating officer during the subsequent investigation.

7 If an allegation of sexual abuse is disclosed days after the alleged offence, it may still be possible to collect forensic evidence. Do not assume that it is too late. Let the police decide.
Trading Standards Role

There is a range of activities that may be accompanied by criminal offences, which can be addressed by referral to Trading Standards as well as to the police. These include the activities of rogue traders, bogus callers and distraction burglary, scams and loan sharkning.

Rogue traders often intimidate, manipulate or threaten their victims into parting with large amounts of cash and in some cases, into signing over their properties. These incidents often remain hidden. Victims are targeted through cold calling either by telephone, or more often by doorstep visits. The rogues will often target an area meaning that any identified victim may indicate other unknown victims in the vicinity. They will often use lines like

“I noticed you appear to have a roof tile loose, I'll have a look for you”

“We are doing work down the road for the Council and have some tarmac left over”

“We've done some work for your neighbour and she said you might be interested”

The “traders” will not provide any paperwork, will quote prices that increase dramatically when the victim has to pay, or will find extra jobs that need doing and increase the final price charged.

Distraction burglary, often called ‘bogus callers’ or ‘burglary artifice’ is a crime primarily targeted at vulnerable older people. Offenders pose as officials (including council, police and utility workers) in order to gain access to homes. Once inside the victim is distracted and the burglary is committed. Other examples are where the offender(s) will pose as a motorist who needs some water for his/her car and whilst the victim goes to fetch the water, the offender(s) slips into the house quickly and steals money or other items within their reach. Sometimes it will be somebody engaging the victim at the front door while an accomplice goes to the back of the house and enters, if possible and commits the burglary.

Scams are mass marketing fraud, perpetrated by criminals and aimed at the most fragile members of society by "working" from mailing lists which categorise people as being elderly or vulnerable in some way, they then contact them by letter, phone or email and try to trick them into parting with cash. Those who respond often end up having their details put on what criminals call "suckers lists". They sell these lists to other scammers all over the world. Millions of victims have a condition which the Think Jessica campaign is trying to get recognised as Jessica Scam Syndrome (JSS).

The most common form of scam is Scam Mail, which can result in victims being delivered 100+ scam letters a day.

Scam mail may use statements like

You have won a lottery, sweepstake or competition... BUT YOU HAVE TO SEND MONEY

Money you have won is being held in a holding company... BUT YOU HAVE TO SEND MONEY

Somebody has left you an inheritance... BUT YOU HAVE TO SEND MONEY

A clairvoyant can stop bad luck or direct good luck towards you... BUT YOU HAVE TO SEND MONEY

There is a "secret" deal which will make you rich... BUT YOU HAVE TO SEND MONEY

Scammers send out catalogues selling food, pills, potions, jewellery, clothes, items for home and garden. They guarantee a prize to those who order and make it appear like 'you' are the only one to be getting this amazing offer. They never send the promised prize (though some do send "cheap" goods to keep the victim on the "hook") Instead they send out more promises to get more orders!
Loan Sharks

This is a well known criminal activity involving unlicensed lending with high repayments for loans that may never end. The victims receive no paperwork. The lenders may use threatening or abusive behaviour to ensure they are paid, and this repayment may even increase. The victims may be targeted when they are due to get their pension or benefits. In many cases the victims are scared of the lenders, but they may also have a relationship where they believe that the lenders are friends and that the victims owe them. This can make loan sharks difficult to spot. If the victims have mental health issues this may also be exploited.

There is also the possibility that this is directly related to victims of scam mail and rogue trading where that is why they may have targeted them.

The effects of these above events are often devastating for the victim. They may not have told anyone about what has happened to them so the first sign of problems may be when there is; an unexplained inability to pay for household shopping or bills, large unexplained withdrawals of money, possessions may have gone missing and/or living conditions deteriorate. It is often at this point that the possibility of abuse may be raised by family members, care workers, housing agencies or organisations whose bills are not being paid.

Research has highlighted the sense of guilt, and the effect it has had on the victim's sense of safety, sanity and health. Many may become withdraw, isolated, reclusive and fear going out or speaking to anyone. In some instances a move to a care home may be considered, as the victim is too frightened to remain at home.

*Where the victim is a vulnerable adult the use of the adult protection protocols can provide an opportunity to consider a range of options available to provide environmental safeguards or alternative support to enable the victim to remain in their own home.*
Financial abuse

Financial abuse as identified in 'No Secrets' includes 'theft, fraud, pressure around wills, property or inheritance, misuse or mis-appropriation of benefits'.

This guidance particularly focuses upon the abuse of vulnerable adults' personal funds (whether in their possession or held on their behalf), their savings and their possessions.

For more information please see Social Care Institute for Excellence Assessment: Financial Crime Against Vulnerable Adults - Report 49

General principles

- Where a vulnerable adult is able to make informed decisions and is able to handle their own financial affairs they should be encouraged and supported in doing so.

- The financial assets and possessions belonging to vulnerable adults are for their benefit. Their use by others without the vulnerable adult's full knowledge and informed consent, or the knowledge and agreement of someone appointed to act on their behalf, can sometimes constitute financial abuse, e.g. theft or misappropriation of property and may well be a criminal act.

- The arrangements for providing support and assistance to a vulnerable adult in managing their financial resources must be open and transparent. However, vulnerable adults are also entitled to privacy about their financial circumstances.

- Health and social care workers must behave in a professional manner with any vulnerable adult for whom they provide care, support or treatment. All practitioners supporting vulnerable adults hold a position of trust and their actions in respect of the clients financial/material affairs must at all times be transparent.

- The need for a vulnerable adult to have assistance in managing their financial affairs should be identified during the assessment and review process. This should include assessment of the service user's ability, risk and suggestibility to undue influence. The specific requirements should be clearly defined. They may, for example, be described generally in a service specification document and specifically in the vulnerable adult's care plan. They may vary according to need and could range from the need for assistance or advocacy to receivership. Even where an individual lacks capacity they should be engaged as much as possible in decisions about spending their money. Service users with mental capacity should be encouraged to consider planning ahead by seeking legal advice about, for example, making wills and/or to give Enduring Powers of Attorney.

- Accountability for the provision of such financial support and assistance must be specified i.e. clearly attributed to named individuals within agencies providing health and social care.

- Those who work with vulnerable adults have a duty to protect them from financial abuse and to report any concerns or irregularities. The ethos of care services should be both to prevent abuse and to encourage and enable open reporting ('whistle-blowing'). This includes the provision of effective support to whistle-blowers.
The Role of Assessment, Commissioning and Inspection

Roles and responsibilities

Effective prevention and detection of financial abuse is the responsibility of all parts of the health and social care system. All staff, whether they are assessors, commissioners, regulators or providers, have a part to play. Effective co-ordination and communication between each of these elements is essential to ensure that vulnerable people are as well protected as possible.

Assessors

The NHS and Community Care Act 1990 states that a local authority must assess a person's needs for community care services if it appears to the authority that he/she may be in need of such services. The assessment of a vulnerable adult should include recognition of their present and likely future needs in respect of the management of their financial affairs, their money and other assets.

Vulnerable adults may, or may not, have mental capacity and their condition may be stable, improving or deteriorating. Depending on the person's capacity various options for managing a person's money or property exist. The assessor should ensure that responsibility for this function is addressed at the care planning stage.

The functions may be fulfilled by relatives, professionals, or statutory agencies and consideration of who should undertake this role should be part of the risk and wider assessment process. If an applicant for care has substantial financial assets, they or their representative should be advised to seek guidance from a professional advisor who is covered by the financial services authority. Where legal provisions are already in place the assessor must see evidence of Enduring/Lasting Power of Attorney or Receivership/Deputyship during the assessment. Provision of services to help with money management vary across localities and authorities. Where services are not provided in-house the local authority should at the very least advise the service user or his/her representative of how they can obtain appropriate advice and assistance. (See also: sec 29. National Assistance Act 1948). The Secretary of State directed that local authorities provide such advice and support as may be needed to people [to whom sec 29 applies] in their own homes and elsewhere. Where this advice includes advice on welfare benefits it should be provided by workers specially trained for such work and with direct access to up to date information on welfare benefits. The review process provides an opportunity to see if safe arrangements have been made and, if not, if further action is required.

Commissioners and contract officers

Commissioners should have regard to the need for appropriate services to be available to assist service users with the management of their money and other assets and of the need to prevent and protect service users from financial abuse.

Service specifications should set appropriate high standards for the safe keeping and management of service users money and assets. For care homes and supported accommodation these should be at least in accordance with the National Minimum Standards for Care Services.

The contract monitoring process should measure performance against these standards and any additional standards within the service contract.

Regulators/inspectors (CQC)

National minimum standards for all client groups were issued under the Care Standards Act 2000. These standards provide requirements to enable service users to control their own money except where they do not wish to or they lack capacity to do so. Providers are also required to protect service users from financial abuse.
Minimum financial and accounting standards/controls in care homes and supported living

This section relates to personal funds and monies collected on behalf of, or held for the personal use of, service users who need assistance in administering their financial affairs and who live (or are temporarily resident) in care homes or supported living settings. The level and type of assistance provided should be proportionate to the needs and risk assessment of the individual. The term 'funds and monies' is wide ranging and includes sums payable by way of earnings, welfare benefits such as the personal allowance or disability living allowance (mobility element), donations, bequests and gifts from families, and any allowances paid by a local authority for the personal use only of individual service users. Separate, detailed, records should be kept of all such sums received, collected or expended on behalf of the respective service user.

Safe keeping and banking

A separate, designated, bank, building society or post office account should be maintained by or for each service user. Advice received from the British Banking Association (BBA) states that, although there is not yet an agreed common approach, a bank may generally base the decision on whether to accept the risk of a third party running an account without obtaining a Court of Protection Order on two factors. These are whether the third party is able to provide evidence of both:

i  vulnerability/incapacity and  
ii  their relationship to the vulnerable person.

BBA advice is that evidence of (i) vulnerability/incapacity might include:

- a letter addressed to the bank from the customer's medical practitioner clearly specifying that the customer is unable to manage their financial affairs;
- a letter from the court of protection, public guardianship office or solicitors acting for a proposed receiver/registered power of attorney advising the bank that an application to the court is being made;
- a letter from social services or the local authority advising that the customer is unable to manage their financial affairs.

Example of (ii) relationship to the vulnerable person might include:

"if the third party has been granted the authority by the Department of Work and Pensions (DWP) to collect benefits on behalf of the vulnerable/incapacitated individual as evidenced by:

- a letter from the DWP
- a DWP form"

BBA advice is that when opening a bank account on behalf of a mentally incapacitated person, both the third party and the individual for whom the account is being opened will need to be identified and verified according to the bank's usual procedures.

The practice of 'pooling' funds belonging to more than one service user, within one composite current account is not acceptable or prudent. Neither is the resident's account to be used by the home in connection with the carrying on or management of the home.
Where the service user has accumulated large sums of cash in their current bank, building society or post office account(s), the service provider should formally notify the respective care manager/social worker of this situation (if the service user has capacity their permission should first be sought). Where a Receiver has been appointed by the Public Guardianship Office for a service user, it is imperative that the views of the Receiver be obtained at the earliest opportunity. What constitutes a large sum of money will depend on individual perspective and setting. For the purposes of this guidance a figure of £3000 is considered to be appropriate. Where service users have several accounts this figure should be cumulative. The care manager/social worker, after discussion with the service provider about the service user’s anticipated personal expenditure needs, should give consideration to the appropriateness of establishing a separate deposit account in the service user’s name.

The signatories authorised to make payments by cheque, or withdraw cash from the bank, should be determined by a senior level of management in the service provider organisation. In situations where the service provider organisation does not have different management tiers, e.g. a small home, the determination should be made by the owner/manager. Maximum financial limits should be set regarding the amount of any single cash withdrawal; and the amount for which cheques may be issued by a single authorised signatory. Cheque payments above the specified maximum limit should require two authorised signatories. Particular vigilance should be exercised by all parties with an interest in, or responsibility for, protecting the service user, to ensure financial limits are not evaded by splitting a single transaction into two or more smaller amounts.

The practice of using pre-signed, blank, cheques is extremely imprudent and should be forbidden.

At least once a month, a statement should be prepared reconciling the recorded balance(s) on each service user’s Personal Cash and Bank Record with the Actual Total amounts held at the service user’s residence and at their bank. This reconciliation should be formally certified, as correct, by an officer responsible for administering service users’ personal finances; and verified, at least quarterly, by a separate designated more senior manager. In situations where no separate senior management level exists an appropriate alternative arrangement should be agreed as part of the commissioning and contracting process.

Cash or cheques held at the service user’s residence should be kept under secure conditions. This should involve a separate, lockable box for each service user’s monies. Responsibility for the physical custody of, and access to such boxes should be specified by senior management.

Record keeping

It is important that all information is recorded clearly, concisely, accurately and promptly.

- An accounting record should be maintained of all transactions involving the service user’s personal banking account including cheque payments made through the account together with any cash withdrawals from, or deposits into, the account. This personal banking record should also incorporate provision for a signature by the officer responsible for initiating transactions of any nature on the service user’s bank account; and include balances brought/carried forward. These records should be verified against banking statements or pass books.
- A separate basic accounting record (i.e. cash account) should be maintained for each service user recording all cash received, or spent, on their behalf. Each account should normally cover a period of one month and incorporate balances brought/carried forward to the next month.
- The format of the cash account should provide for, among other things, a clear ‘audit trail’ regarding cash paid into, or withdrawn from, the service user’s bank account; and the signature of the officer responsible for initiating the respective transaction(s). This cash record should reflect a clear picture of monies spent/collection on behalf of the service user.
- Receipt and payment entries should be supported by relevant, verifiable, documentation. Minimum financial limits should be set above which invoices/expenditure vouchers must be obtained; and below which supporting documentation may not be considered practicable or of material financial significance.
• Manual deletion or erasure of entries on accounting records (including details on invoices supporting service user personal expenditure) should not be permitted, especially by use of tippex. All transaction entries on service users' financial records should be in ink. Where, occasionally, it might be necessary to alter or amend, for example, recorded totals (for instance on discovering an arithmetical error) the following approach should be adopted: a short line should be drawn through the incorrect figure; the correct figure written next to it; and the amending entry clearly initialled by the originating officer.

• Financial and accounting records relating to service users personal expenditure should be retained for the current financial year and the preceding five years (total six). This includes situations where the service user moves or dies. (NB This guidance should be cross referenced with local authority practice and procedures for when a service user dies).

Expenditure

• Clear guidance should be issued by service providers regarding what they (and the service commissioner) consider proper professional practice where the personal funds of vulnerable adults are being spent. This could comprise a list of 'dos' and 'don'ts'; and cover contentious areas (such as the costs and expenses of care staff accompanying service users on holiday) where monies might be removed from the service user's account to meet expenditure from which the service provider/staff may directly or indirectly benefit.

• Clear guidance should also be issued regarding the policy on care staff accepting (or otherwise) cash, personal gifts or hospitality from service users or from their families and friends.

Inventory of personal possessions

A simple basic inventory should be constructed, and kept up to date, of valuable personal property belonging to each service user. By way of a non-exhaustive list for illustrative purposes only, this could include items such as portable TVs, cassette players, music centres, personal jewellery, leather handbags. The inventory should be updated and certified as correct, at least 6 monthly, by an officer responsible for administering service users' financial affairs; and verified, annually, by a more senior manager. Any missing items should be fully investigated in accordance with local adult protection procedures where necessary, and a proper explanation recorded on the service user's personal file. The inventory should also be formally amended, as necessary, and a brief explanatory note added to the inventory (and cross referenced to the service user's personal file/records). Instances of suspected theft must be reported immediately in accordance with local adult protection procedures.

Personal credit cards

The use of staff members' personal credit, debit or loyalty card(s) to process the private expenditure of a service user should not be permitted.

Joint purchases

• Whilst people in residential accommodation, who have full mental capacity, may opt for shared purchases/ownership e.g. purchase of a car with their disability living allowance, (mobility component), they should not be placed under any pressure to engage in joint purchases or partake in such arrangements. Providers and/or care managers/social workers should offer advice and support to ensure that any such agreements will facilitate proportionate benefit and be in the best interest of the service user and fit for purpose in the short, medium and long term.

• In the case of people who are assessed not to have mental capacity to manage their finance, consent to any proposed joint purchase on behalf of the service user should be obtained in writing from the person who holds Power of Attorney/Receivership.
The best interest of the service user should be paramount and any purchases must be fit for purpose in the short, medium and long term facilitating proportionate benefit to the service users.

- Any such joint purchases should be confined to use by the service users and should not be available for use by staff only, without the service users. A written agreement should be provided to each service user, confirming their continuing ownership rights of any joint purchases. Staff must ensure the proper care and servicing of any (joint) property, such as a vehicle, which is used by staff for the benefit of service users.

Monitoring and periodic professional audit

- Regular checks should be undertaken by both the service provider and service commissioner to ensure the service user's interests are being protected. These checks may be undertaken by, for example, a contract monitoring section or line management staff in either the service provider or local social services. Whatever types of monitoring mechanism are adopted, the checks conducted should, as a minimum, seek to verify that:
  
  - expenditure is well documented.
  - it has been incurred for the service user's benefit, and
  - the recorded balance of monies on the service user’s cash account and personal bank record can be clearly corroborated by physical verification and independent documentation e.g. proper statements for the service user’s bank, building society or post office account(s).
  
- Each care provider should also ensure that the personal funds of vulnerable adults for whom they have day-to-day responsibility are subjected to periodic, in-depth, professional audit at intervals not less than once every 4 years. If the service provider or care commissioner operates an established, suitably experienced, internal audit function the necessary review might, alternatively, be conducted through this mechanism.

Transparency and information sharing

- Where a service user possesses capacity and does not wish details of their financial affairs to be disclosed to any other party (except those expressly authorised in law), the service user’s wishes should be respected.

- Where, however, the service user does not possess the mental capacity and for example, there is a Public Guardianship Office appointed Receiver, then any such Receiver should be afforded full access to information concerning the service user's financial affairs. It is noted that some service providers already provide the facility of making such records available, on demand, to DWP inspectors, social services departments, health authorities and the advocate of the respective resident. Whilst it is impossible to prescribe for the circumstances surrounding every service user, transparency of practice should help minimise the possibility or risk of any misappropriation remaining undetected.
Managing Confidential Information in Documents, Reports and Minutes of Meetings

Any decisions made by the social services agency to seek confidential information from another agency should be recorded on the alert/referral form and/or in the minutes of any planning/strategy meeting, as well as on any individual record held for the vulnerable adult or the alleged perpetrator. Consent to the disclosure of third party information should be obtained when the information is provided if at all possible. This will enable third party information provided in the course of an investigation/assessment or at planning/strategy meetings or case conferences to be marked ‘Open for access’ or ‘Not to be disclosed beyond the remit of the adult protection process’. All confidential adult protection information marked ‘Not to be disclosed’ will be placed with all other adult protection information in the closed section of the client’s file.

Minutes to be circulated should be marked ‘Highly Confidential’ and care should be taken to ensure secure storage and appropriate access controls are in place. The file copy of the minutes will show the full names of all of the attendees and those who sent apologies together with the authorities/agencies/services they represent. Only the file copy will include the full names of the victims, vulnerable witnesses and vulnerable perpetrators. When the minutes are circulated, the initials should be substituted for the full names of the victims, vulnerable witnesses and vulnerable perpetrators.

The Data Protection Act 1998 (DPA) came into force in March 2000 and gives individuals a general right of access to the personal data that relates to them. The social services ‘data subject access request’ procedures provides more details on what information can be disclosed and what is exempt from disclosure.

The DPA provides for sharing of information when required by other bodies as long as this is ‘the minimum necessary to meet the requirements of the situation’ and is necessary to enable the authority itself to discharge its statutory functions. Protection of vulnerable adults is one of those functions.

The formal minutes of planning/strategy meetings and case conferences are a record of the issues, outcomes, decisions and recommendations. They should be marked ‘Confidential’ and be available only to those participating in or invited to the meetings. It is the responsibility of the local authority circulating the minutes to ensure that they are sent by secure email where available, secure fax or recorded delivery.

The reports and information gathered to inform the meeting and the decision-making process should only be available to those professionals directly involved in the process. However, in certain circumstances it may be necessary to make the minutes of adult protection meetings available to solicitors, the civil and criminal courts, psychiatrists, professional staff employed by other social services agencies or other professionals involved in the welfare of the vulnerable adult(s). Any such disclosure must be recorded.

If requested, a summary of outcomes and recommendations from the case conference should be made available to other parties on a ‘Need to Know’ basis and when it is in the ‘Best Interest’ of the vulnerable adult(s).

A statement of confidentiality together with the equal opportunities statement below should be placed at the top of the attendance list for meetings and on the first page of the minutes.
Statement of confidentiality

This meeting/conference is held under the multi-agency adult protection policy and protocols and Guidance for Kent and Medway. The matters raised are confidential to the members of the meeting/conference and the agencies that they represent and will only be shared in the best interests of the vulnerable adult, and with their consent where it is appropriate to obtain it.

The minutes of adult protection meetings are not a verbatim record of the discussions but they are a summary of the discussions and a record of the actions identified to be completed by whom and when. Minutes of the meeting/conference are distributed in the strict understanding that they will be kept confidential and in a secure place.

The information you have provided will be held and used by Kent / Medway Councils for the purpose of this Adult protection enquiry. This process may require us to share this information with partner organisations and other local authorities or agencies to support the protection of vulnerable adults or children.

In certain circumstances it may be necessary to make this information and/or the minutes of this meeting available to solicitors, the civil and criminal courts, the Disclosure and Barring Service in relation to Vetting and Barring, psychiatrists, professional staff employed by other social services agencies or other professionals involved in the welfare of the vulnerable adult(s) or children. Any such disclosure must be recorded. Information may also be disclosed under strict controls in relation to a Freedom of Information Act 2000.

Equal opportunities statement

The Kent and Medway adult protection policy and protocols recognise that certain people are the subject of discrimination and disadvantage. Comments that contribute to this discrimination are not acceptable and will be challenged by the chair and other meeting/conference members.
Supporting People

Supporting People is a housing support initiative that contracts with service providers for housing related support services. It covers every client group that social services work with in addition to other vulnerable groups. Provision includes accommodation-based services, floating support services, community alarms and home improvement agencies.

The Kent Supporting People Team is based at County Hall, Maidstone and is part of the wider Commissioned Services Team. They act as a payment and contracting function. Approximately 10,500 service users in Kent receive support under this programme in both accommodation-based and floating support services.

As part of the contracting function, providers are monitored for the quality of their service provision.

The Supporting People team will normally be made aware by service providers of adult protection issues through their contractual responsibility to report them. The team may also be made aware through social services or health colleagues. The team maintains a log of reported adult protection issues. Serious incidents reported by service providers which don’t require a safeguarding form to be completed are also logged.

In the event of becoming aware of an adult protection issue, the Supporting People service provider will refer to the social services team for the appropriate client group in the locality in which they are living. It is the duty of that team to progress the adult protection alert in the normal way.

In the event of an adult protection alert being raised by social services, client systems should be checked to determine if the client receives a Supporting People service. If so, the Supporting People team should be notified of any alert or subsequent proceedings so that they can decide if there is a need to review the service. The service provider should be invited to attend adult protection meetings, and the Supporting People team will attend if appropriate and should be copied into minutes and decisions. Not all Supporting People service users will be on client systems so it may be necessary to check whether the individual is known to the team.
Adult Protection Referral Checklist for the Social Services Agency

When information about abuse or suspected abuse of a vulnerable adult is received, the alert/referral form must be completed immediately by the first trained and experienced member of staff receiving the information in the social services agency. (This member of staff should have received levels 1 and 2 adult protection training). If the vulnerable adult is not resident/or on respite in the locality receiving the information and completing the alert/referral form, telephone contact must be made with the designated senior officer (DSO) in the relevant locality / team (where the client lives) to inform them of the issues of concern. The alert/referral form must then be e-mailed to the DSO. The DSO may be a senior manager, service manager, team leader/manager, safeguarding adults co-ordinator or senior practitioner. Phone contact is essential, do not rely on e-mail.

If the allegations appear to relate to abuse occurring within services managed by an Acute Hospital Trust follow Protocol section 17

The following points will assist staff to manage the adult protection referral process:

a. Start to complete the alert/referral form as a word document.

b. If the initial alert refers to more than one named vulnerable adult, then alert/referral forms should be completed for all those named as victims.

c. If the alert relates to a vulnerable adult in a care setting or a domiciliary agency is involved the CQC must be informed.

d. If at any time during the process of consultation, inquiry, evaluation of information, planning, investigation, or assessment, it becomes apparent that other named service users may be at risk or have suffered abuse then alert/referral forms must be completed for all those named.

e. Determine if the vulnerable adult is aware that an adult protection alert has been raised and that investigation/assessment will follow. This may not be possible or appropriate in some circumstances. Ensure that issues of consent are recorded.

f. Determine from the records if this vulnerable adult, alleged perpetrator or the setting has previously been the subject of adult protection concerns.

g. Discuss the concerns with your Line Manager (LM)/DSO in order to determine level of risk from information available, prior to consulting with other agencies. Record the outcome of your discussions on the alert/referral form and any reasons for believing that the alleged victim or others are at risk of significant harm at this time. Consider the consequences, the likelihood of their occurrence and any immediate protective / emergency actions to be taken prior to other agencies being consulted. Record on the alert/referral form the identified level of risk and any actions taken.

h. If there is any possibility that a criminal offence may have been committed ensure the police are contacted and/or consulted by phone before action is taken, unless to do so would cause undue delay and result in significant harm to the vulnerable adult(s).

i. Referrals from the social services agency to the police should be made using the alert/referral form.

j. Following discussion with LM/DSO consult with agencies that may have information about the victim, the alleged perpetrator and/or the setting. This is not an investigation of the issues that caused the alert to be raised but an opportunity to gather information to allow a full evaluation and assessment of the adult protection concerns. Record on the alert/referral form a summary of discussion and outcome with each consultee.

k. Following the consultation with other agencies/services, discuss with your line manager the summary of the information now available. This will enable an evaluation of the concerns and a revised level of risk to be agreed and recorded together with the reasons. There must then be a determination of the most appropriate course of action.
This may include: e.g., emergency protection, planning/strategy meeting, care management assessment, referral to more appropriate agency/service? This must be recorded on the alert/referral form.

E-mail a copy of the partially completed alert/referral form to the team administrator to enable the alert information to be entered onto the adult protection database. As additional information becomes available, this should be added to the alert/referral form and passed to the administrator to add to the data base.

If it is considered that the concerns reported are to be addressed by an alternative to the adult protection process the case must be signed off using the alert/referral form which must record the alternative disposal and the reasons for this decision.*

Where adult protection concerns are raised around the time of death of a vulnerable adult, the coroner’s office must be informed of the adult protection issues as a matter of urgency. The police will normally do this.

The Line Manager/DSO should complete the allocation section, naming an appropriately trained and experienced practitioner to act as the Investigating Officer, to ensure continuity, consistency and close monitoring of any actions taken regarding the alert and any further action indicated.

It is strongly recommended that all records of consultations, discussions and decisions taken are recorded on the alert/referral form and/or on separate contact sheets and are countersigned by the LM/DSO.

If either the victim or alleged perpetrator is a service user funded by an authority other than Kent or Medway, the funding authority must be informed of the issues as a matter of urgency.

If the issues of concern involve a service accommodating users placed by authorities from outside Kent or Medway and at this point it appears that there may be risks to other vulnerable service users, consideration must be given regarding the need to inform all of the placing authorities of the issues, as well as informing those funded by other localities in Kent.

If the issue(s) of concern appears to be serious and it is believed that other service users may have been abused or are at risk of abuse, all placing authorities must be informed and given the opportunity to attend the planning/strategy meeting. This decision should be taken by the DSO, or senior manager, based on an evaluation of the information available.

Information about other service users and their placing authorities should be requested, as a matter of urgency, from the service provider. The decision to inform or not to inform other placing authorities and localities may be taken at the alert stage or following the planning/strategy meeting if the initial information was unclear or the incident(s) appeared less serious. The decision to inform other placing authorities must be recorded. They may be informed by telephone or fax. This must be recorded on contact sheets within the adult protection case papers.

*When a trained and experienced professional staff member of the social services agency completes a alert/referral form because they believe from the information they have received that a vulnerable adult has or may have been abused this information must be entered onto the Adult Protection database as a record of the concerns received.

If following discussions with other agencies/services and consultation with the DSO there is an agreement that the concerns will be addressed in another way, the adult protection process can be halted and the case signed off by the team manager/service manager who has not been directly involved in the case. The closure form must be completed recording how the concerns are to be addressed, by whom together with the reasons for this decision.
Adult Protection Operational Guide for the Social Services Agency Staff

All actions, decisions and communications must be immediately and clearly documented throughout the Adult Protection process including the reason why they have been made.

All communications and information sharing throughout the process must be made with due regard to maintaining appropriate confidentiality.

Concerns about possible abuse reported to the social services agency

Is it Adult Abuse?
- Is the person a vulnerable adult? (Ref. 3.2 - Policy, 4.7 - Protocols)
- Is it Adult Abuse, complex casework, or something else? (Ref. 3.1 - Policy, 4.7 - Protocols)
  a) Yes
     - Inform and advise your designated senior manager (DSO). (Go to 1 below)
     - Proceed to completing the alert/referral form (as far as possible). The word document is on the care management forms template.
     - Pass to designated administrator for input onto adult protection database.
  b) Not sure
     - You and your DSO will need to gather more information to enable as an initial evaluation of the concerns to be made to determine whether or not the person is a vulnerable adult (in line with ‘No Secrets’ published definition) and to establish whether or not the allegation constitutes abuse.
  c) No
     - It is good practice to signpost to other agencies e.g. CQC, Victim Support, Legal advice.
     - Or to deal with it under usual the Care/Case Management Assessment process.
     - To address the concerns through the safeguarding adults quality in care framework

You now have an alert

Two immediate considerations (In conjunction with your Line Manager or the DSO consider)

1. Immediate safety. Explicitly record what action has been taken to minimise risks to:
   - the vulnerable adult
   - other vulnerable adults
   - or any children who may have been affected by the concerns reported

You cannot ask a service to suspend a member of staff. You can ask them how they intend to keep vulnerable people safe e.g. this may mean they suspend the person, move them to another service or shadow them. Advise them that they should follow their adult protection procedures, employment law and staff disciplinary procedures.

2. Police
   Is the matter, as reported, likely to constitute a criminal offence or will the involvement of the police support good practice? Contact the Combined Safeguarding Team in your force area they will provide guidance, to prevent contamination of evidence.

What happens next?

The DSO or duty senior will decide:
Who will act as the DSO for this case and co-ordinate the adult protection process?
This may be a Team leader/manager, safeguarding adults co-ordinator or senior practitioner.

3. GP
   Consider if it is appropriate to inform the GP of the adult protection concerns reported and /or quality in care issues.

Next steps
Planning process may be undertaken by: by telephone, face to face discussion, formal planning/strategy meeting, or all of these methods

Purpose of the planning process is to share information and decide/agree any actions
Decisions may include:
• Level of risk
• Does the vulnerable adult understand the risk and potential consequences
• Mental capacity – Record known information and consider if a MCA is required.
• If the vulnerable adult lacks or appears to lack mental capacity to make decisions related to their safety consider liaison with relatives initially and keeping them informed about the progress of the case.
• Which agency takes the investigative lead e.g. If crime - police.
• Who is going to be involved
• If financial abuse do you need to make contact with the Office of the Public Guardian?
• Time scale
• Status of alert i.e. open/closed
• With whom you need to share the information and how
• In high profile cases prepare a briefing for Senior Managers and the Press Office
• Consider if any issues raised may affect children or other vulnerable adults(directly or indirectly)
• Is ISA referral indicated at this time
• Date of next meeting

You may want to consult with or invite to a planning/strategy meeting:

<table>
<thead>
<tr>
<th>Health</th>
<th>SSD</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Nurse</td>
<td>Care Managers</td>
<td>CQC, Police</td>
</tr>
<tr>
<td>CLDT</td>
<td>Contracts</td>
<td>Legal representation, Housing</td>
</tr>
<tr>
<td>CPN</td>
<td>Social Workers</td>
<td>Care home, Service user/advocate</td>
</tr>
<tr>
<td>GP</td>
<td></td>
<td>Family</td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td>HR representative</td>
</tr>
</tbody>
</table>

Investigation
Proceed as agreed at the planning stage. This may involve joint assessments, interviews, supporting the vulnerable adult. Care Management review, finding alternative accommodation etc.

Formal review of the findings from the investigation/assessment. This process could be the same as at the planning stage. May be by:
Telephone, face to face discussion, case conference, or all of these options
Decisions for consideration may include issues listed above and will also need to include:

Decision making and record made regarding the outcome of the investigation/assessment, did the abuse happen as alleged? Did the person suffer harm as a result of an act of omission or commission by another whether this act was intentional or not.
Were the allegations
• Discounted or Unsubstantiated
• Confirmed or Substantiated
• Partially Confirmed or Partially Substantiated (Some aspects of the abuse were confirmed)
• Insufficient Evidence or Not determined/Inconclusive (there was not sufficient Evidence available to enable a decision to be made about whether the person was abused / suffered harm)
or
• evaluated as not being adult abuse

If the abuse was confirmed and you know who was responsible, what was the basis of this decision?
• on the balance of probability, this would normally be chosen and can be updated on the records if a prosecution is successful
• guilt was admitted,
• prosecution recommended or to follow.

Further Actions
• Inform relevant people of the outcome of the investigation e.g. agencies involved, service user, care setting, family, referrer.
• Agree and record post abuse support plan
• Agree any monitoring of the service.

Closures
When the Adult Protection Case Conference recommends closing the alert:
The DSO must:
Audits the case using the agreed audit tool
- Complete the alert/referral and closure form.
- Passes all papers to the Locality Head of Service/service manager/associate director for sign off.
- They pass all the papers to local administration officer.
- Local administration officer completes the adult protection closure on the AP system.
- Adult Protection case papers to be stored in the 'closed' section of the client file.
- If the case was co-ordinated by a host locality or authority they should retain the original AP papers as they were responsible for the work and the placing locality/authority should have copies to be placed in the closed section of the clients file.
- DSO and Senior Manager consider possible need for formal debriefing and arrange as per protocol

**NB. Even if the police do not pursue and criminal investigation/prosecution, the case must be referred back to the safeguarding meeting to decide if abuse happened ‘On the Balance of Probability’.**

**NB. Even if the concern refers to a community health service The Social Services Agency have responsibility for co-ordination.**
Adult Protection Planning Checklist

A decision about how to proceed following the receipt of information that has caused an adult protection alert to be raised may be made in two ways:

1. Planning consultation with other relevant agencies, departments, services or people by phone or within the team. This must be recorded. If no formal planning/strategy meeting is to be held, it should be clear who made that decision and why e.g. sufficient information is already available to allow action to be taken e.g. care management assessment.

2. Holding a formal planning/strategy meeting to share information and to aid decision-making. The meeting should involve all the people who may have information to contribute to the planning process. This may include a provider who may be invited to all or part of the meeting. Exceptions will be where they may be implicated in the alleged abuse or where there are good grounds to believe that their presence may impede the sharing of information and/or the investigation. In addition, invitations may be extended to the client, carers/family.

Whichever route is chosen, clear recommendations and actions must be recorded.

It is important to note that consultation and inquiry at this stage should enable an evaluation of the issues and should not become an investigation of the facts about the alleged abuse.

The following issues will need to be considered in most cases:

a. Is there any medical evidence or record of the impact of the abuse?

b. Has there been a disclosure or a report? Has it been signed and dated?

c. Are there any issues of discrimination, which need to be considered?

d. Is any documentary evidence available? E.g. bank statements, accident/incident reports.

e. Is there any record of the vulnerable adult being contacted or consulted about the alleged abuse?

f. Has the vulnerable adult's capacity to consent been considered and is there any information or are there any reports available regarding their capacity?

h. Is their consent to be over-ruled in the interests of other vulnerable adults or children?

i. Have the vulnerable adult's wishes been recorded regarding the allegations and in respect of their desired outcomes?

j. If a care home, domiciliary service or community health provision is involved have CQC been informed.

k. If the service has not already been informed of the adult protection concerns, the designated senior officer (DSO) will decide when and by whom they should be advised of the issues. A decision on this matter may be delayed until a formal planning/strategy meeting is held if it is unclear whether the service may be implicated or contamination of evidence is likely.

l. If there is a possibility that other service users may be at risk, the local authority should obtain from the service provider the following information: The names of all the service users together with information regarding their funding status and the identity of placing authorities. This information should be passed to the DSO as a matter of urgency. The DSO should then inform other placing authorities of the issue of concern regarding their clients. This information will enable them to attend the planning/strategy meeting or make their views known to the DSO. Careful consideration needs to be given to informing all residents and their next of kin, including self-funders.
m If a home or organisation has a KCC/Medway contract, have commissioning been consulted? Is any action required, regarding the contract, prior to any investigation being carried out? Contract actions need to be agreed and recorded between the commissioning manager and the DSO/Assistant Director/Locality Head of Service/Service Manager regarding any variation to the contract. e.g. temporary suspension of placements.

Commissioning services will be responsible for:

- Informing the home of any actions taken which affects their contract.
- Alerting care management teams, via the contract database or e-mail system of any issues which may affect the use of any service.

Either with or without a formal planning/strategy meeting, the DSO must ensure that there is a full record of the consultation/planning stage. This might include:

a Which agencies were consulted and or represented at the planning/strategy meeting.

b That the minutes of any meeting include sufficient detail to establish clearly what decisions were made and why.

c That any investigation/assessment is agreed together with timescales. Co-ordination of the investigation/assessment will normally be allocated to an investigating officer from the social services agency. In some cases the investigating officer may be a named police officer or representative of an NHS organisation.

d In cases where alleged abuse occurred in a service managed by an acute hospital the hospital adult protection lead manager (HAPLM) will normally act as the DSO.

e That there is a record of the terms of reference for the investigation/assessment.

f If there are any concerns regarding mental capacity of either the alleged victim or perpetrator a mental capacity assessment should be carried out and recorded. Consideration should be given to appointing an advocate and consideration given to holding a Best Interests meeting where issues of capacity are in doubt.

g Where the vulnerable adult lacks or appears to lack capacity to make decisions regarding their involvement in the adult protection process and / or their understanding of keeping themselves safe, consider if it is appropriate to liaise with relatives regarding the adult protection concerns and to keeping them informed of the progress and outcome of the case.

h That it is clear who will be involved in all aspects of the investigation/assessment.

i That consideration has been given to the possibility or likelihood that issues of abuse may concern other vulnerable adults or children.

j If criminal matters are suspected what kind of investigation will be carried out?

Ensure that there is a record of concurrent and consecutive actions to be taken by agencies other than the police.

k Any care management, commissioning or regulatory action to protect the vulnerable adult(s) or children is recorded.

l Any decision to take no further action is agreed and recorded. The alert/referral and closure forms are completed. Record who will feed back the outcome to the referrer.

m Any disagreement with decisions taken should be recorded in the minutes of the meeting and discussed by the DSO with senior managers as a matter of urgency.

Amended July 2013
Aide - Memoire for Adult Protection Meetings

If this meeting is an initial planning/strategy meeting it should involve professionals from relevant agencies and may include service providers who may have been contacted as part of the initial information gathering. Attendance from individuals with specific knowledge of the situation is recommended. It should not include anyone who may be implicated in the abuse. (See Guidance Section 22).

It is good practice to meet with the minute taker prior to the meeting to inform them of the possible issues that may be raised. It would be useful to work with the minute taker to set the agenda.

Care should be taken to ensure that minutes provide a summary of the issues covered and action points.

If it is likely that the minutes will need to be used by an employer to make a referral to The Disclosure and Barring Service (DBS) it is important that the names of service users and whistleblowers are anonymised as far as is possible.

Agenda

1. Statements of confidentiality and equal opportunities
   - Read out to all attendees.
   - Send around the attendance list that should be headed by the two statements.

2. Apologies-reasons for exclusion of any person(s)

3. Introductions - Remind participants of the subject and date that the original concerns were raised.
   - Chair to explain briefly the purpose of the meeting e.g.: Adult protection initial planning or review planning/strategy meeting, or case conference
   - Explain the structure of the meeting/conference.
   - Chair to hand out prepared agenda asking for any addition points if necessary.
   - Clarify with the participants their role in this meeting.

4. Outline of Alert in respect of the vulnerable adult(s) or the issues in relation to an establishment
   - The allocated care manager or social worker should summarise how the alert came into the attention of the social services agency
   - If a care manager, social worker is not allocated the Chair should do this using the information from the original adult protection alert/referral form.
   - If the referrer is present it may be appropriate for them to do this.

5. Review of Previous Action Plan - if this is a review-planning/strategy meeting.

6. Summary of information exchanged. It can be useful to identify separate headings for professionals' input:
   - Care management information - history, current status, mental capacity, action undertaken
   - Local Authority Client Financial Affairs Officers (CFAO) – in cases of alleged financial abuse
• Commissioning information - monitoring visits, identified concerns regarding quality; open a discussion about whether the commissioning database should have an adult protection warning flag placed on it and at what level. (See protocols section 8.1)

• CQC information - previous inspections, current knowledge

• Out of hours

• Health Information - who in health is the key worker, current information, historic information

• Police involvement - Do the police consider that a criminal offence may have been committed. Clear indication as to what can be communicated and to whom. Endeavour to set time-scale for investigation. (Consider if a profile of the client may be needed especially if the vulnerable adult(s) has a cognitive or sensory impairment or behavioural problems that will impact on the interview process)

• Housing

• Provider - Have the necessary steps been taken to protect vulnerable adult(s)

• Has consideration been given to referral to DBS?

• Other placing authorities e.g. Local authorities, CCGs or Mental Health Trust

7 Adult protection status. Discuss whether this adult protection alert should be given the status of an ongoing adult protection referral or to close the alert and address the issues in another way e.g. by CQC, complex case management work, commissioning, quality in care framework, domestic abuse.

8 Risk Assessments

• Consider the safety of this individual, other vulnerable adults or children and anyone waiting to be admitted to the home. (See Protocols 8.1).

• Consider whether immediate action needs to be taken to safeguard vulnerable adult(s) or children. This may be necessary even if it risks interfering with a police investigation.

• Document the recommendations/decisions about placing a warning flag on the commissioning database and indicate the level of risk to be noted on the system. Decide within this meeting who is responsible for confirming this information with the service provider.

• Discuss and decide the need to inform other local authorities, care managers, families regarding the level of concern and who should be responsible for this, if this has not already been done.

9 Action plan for investigation of the allegations and assessment of the impact on the vulnerable adult

• Be clear about the terms of reference for the investigation/assessment and who is doing what, how and to what time-scale.

• If this adult protection alert is about more than one person, separate out the action plans so that it is clear who will be involved with each vulnerable adult.

• Ensure that those concerned understand who is the DSO and who is the IO co-ordinating the investigation process.

• Ensure that the investigation/assessment is completed jointly with the appropriate professionals and who should be responsible for completing a written summary of the findings.

• Ensure that any parallel processes are agreed

• Confirm that all present are aware of their role.
10 Decision regarding the need for a review planning/strategy meeting in complex cases.
   • Ensure that the next meeting date is set. This can assist with keeping people to a set time-scale.

11 Consider at this stage whether this might go to case conference.

12 Consider at Case Conference stage the outcome of the adult protection investigation/assessment i.e.
   • Was the abuse confirmed? (Substantiated) – Did the person suffer harm as a result of an action or
     omission to act by another person or persons regardless of any intent to cause harm.
     If so do we know who the abuser was?
     Clarify the basis for the decision: did the alleged perpetrator admit guilt, have they been found guilty in
     court, have they been charged or did the multi-agency meeting agreed guilt from the available evidence
     'on the balance of probability'.

   • Was abuse partially confirmed (substantiated)? (Some aspects of the abuse allegations were confirmed,
     e.g. there was evidence of physical assault but no evidence of sexual assault) Ensure that there is a
     record of the basis for this decision.

   • Was abuse discounted (unsubstantiated)? There was no evidence that the person was abused. Record
     the basis for the decision e.g. an accident occurred that could not have been foreseen.

   • Was there insufficient evidence to determine if the person was abused (harmed) due to the actions or
     omissions of another person or persons regardless of any intent to cause harm)?

13 At case conference give consideration to referrals via employer or CQC to the Disclosure and Barring
   Service (DBS). Also ensure that a local authority representative is nominated (usually the DSO or HR
   representative) to make the referral to the DBS where the employer has not or cannot make such a
   referral, e.g. where the person is the owner /manager or where the person was employed via a Direct
   Payment.

14 At case conference give consideration to referral to a professional body/register e.g. Nursing and
   Midwifery Council, General Social Care Council.

15 Ensure that any post abuse care plan for the vulnerable adult(s) and any actions plans for the service
   provider are agreed and recorded and that any matters which may trigger urgent recall of adult
   protection procedures are clearly identified within the relevant plan(s).

16 Conclusion
   • Include date, time and venue of next meeting (if necessary).
   • Summarise again the recommendations and care/action plan.
   • Agree what will be fed back to the client/family/referrer and by whom.
   • Ask meeting attendees if anything has been omitted that needs to be added.
   • Ask meeting attendees if anyone disagrees with content and decisions made.

17 Close the meeting

Post meeting:
   • The minute taker should send out a record of the agreed action points within 2 working days of the
     meeting, and a copy of the agreed minutes should be circulated within 10 working days unless
     exceptional circumstances make this impossible.

   • The minute taker should ensure that their name is on the document
     e.g. at end … Compiled by Jo Bloggs on … (date)

   • It is also recommended to end the minutes with:
     Agreed as correct … signature … Chair … date
     OR Minutes agreed as correct … Signature … Name and Position, Date
Investigation/Assessment Checklist

The role of the investigating officer is central to the adult protection process. If you are asked to be an investigating officer for a case you should have an understanding of the multi agency adult protection policy and protocols and be appropriately trained and experienced to undertake the task. The AIMS for Adult Protection Guide (Pavilion Publishing) contains extensive checklists to support the investigative process. These can be copied and used to record information or to remind the investigator, in detail, of the issues that may need to be considered.

Where the investigating officer is not a representative of the Social Services Agency, the Designated Senior Officer (DSO) will take responsibility for completing the alert/referral form and ensuring information is added to the database. They are also responsible for maintaining a complete record of contacts in relation to the case.

A summary of your responsibilities includes:

- Completing, as necessary, the alert/referral form and ensuring that it has been input onto the appropriate database. If you have updated any information initially gathered at the point of alert/referral please note that this information has been updated on the form and record your name and the date the update(s) was made.
- Liaising with the DSO if emergency action is required to protect the vulnerable adult(s) or children.
- Keeping a complete record of contacts, meetings, interviews, phone calls and any decisions taken and issues considered to be placed in the closed section of the client's file.
- Recording decisions taken as a result of meetings or consultations with other professionals, service providers, the victim and/or carers.
- Carrying out an assessment/investigation with other agencies, where appropriate, and writing a summary of the findings that will support decision making.

This checklist may assist you to consider specific issues involved in investigation and assessment of cases of abuse or suspected abuse:

1. Do you have clear terms of reference for the investigation/assessment?

2. Consider both the detective and protective aspects of the investigation.

3. Who will support you in the investigation/assessment process? You may carry out some tasks alone (checking through reports or files), but during all interviews and meetings you should have the support of another person. This person may be from: - police, health, service provider, voluntary organisation (e.g. Mencap or Age Concern, Racial Equality Council etc), a funding authority representative or a colleague from your own team. Please consider the cultural religious and gender issues and seek appropriate support.

4. The four main strands of the investigation are:
   - To establish matters of fact.
   - To assess what is needed to make and keep the vulnerable adult(s) safe and to assist them to recover from any trauma.
   - To consider any action which may be taken against the alleged perpetrator.
   - To evaluate the services response to the case.

5. Map out your investigation:
   - What do you need to find out? This should include the wishes and views of the vulnerable adult.
• Who might have this information?
• What legal powers do you have or need?
• Check out all necessary documentation.
• Do you need a mental capacity assessment to be completed in relation to the concerns being investigated?
• Do you need a psychological, psychiatric or speech therapy assessment of any of the vulnerable adults, prior to carrying out any interviews?
• Interview people, in the appropriate environment, taking into account any need for an independent advocate and/or any language, communication, gender or race issues.
• Plan interviews with your colleague prior to commencing the interview.
• Take statements and record interviews; (training in conducting interviews is essential).
• Collate the evidence.

6. Evaluate the evidence obtained:
• Medical or forensic evidence.
• Background reports, service records and previous histories.
• Witness statements from formal/joint interviews.
• Assess individuals' capacity and witness skills.
• Circumstantial evidence.
• Assess the extent and seriousness of the abuse and the effect it has had on the vulnerable adult and others in their network.

The evaluation of each piece of evidence should assist in:
• Proving the allegation.
• Supporting the allegation.
• Being neutral.
• Throwing doubt on the allegation.
• Actively disproving the allegation.

7. You should now be ready to compile your report to enable decisions to be made. Your report does not have to be long or complicated, just clear and to the point, describing what your investigations/assessments have covered and reviewing the evidence in a dispassionate way. If you have worked closely with other professionals, the report can be written jointly and at the very least be jointly agreed as correct.

The following points taken from the AIMS investigators guide should assist you in compiling your report:
• Details of the initial alert.
• Outline of this and any other previous related allegations.
• A pen-picture of the vulnerable adult and his/her circumstances.
• Include a record of the vulnerable adult’s wishes and views about the alleged abuse if they are able to express this. If not consider consulting with family or an independent advocate.
• An assessment of the vulnerable adult, relating to consent and any other legal issues.
• Social situation/network(s) of the vulnerable adult.
• Information about the person alleged responsible (if applicable).
• A description of the investigative process (what was involved) and the level of co-operation you received from the various people involved.
• An evaluation of the evidence.
• Your assessment of the seriousness of the alleged abuse.
• Recommendations about future action(s)/risk(s).
• Location of the cause(s) of the abuse.
• Your opinion and conclusions. Ensure that there is evidence available, in the closed section of the client's file, to support these.

8. Discuss the content of your report with the DSO to enable a decision to be taken regarding the need for a case conference or how the outcome of the investigation/assessment may be appropriately disseminated.
Case Conference Checklist

In cases where an investigation/assessment of issues concerning abuse of a vulnerable adult(s) has taken place, a decision about the need for a case conference should be taken by the DSO. If a formal case conference is not considered necessary, it is essential to provide feedback to all concerned people/agencies; this should include the referrer.

In complex cases involving care services which have been managed as level 4 cases within the framework, the DSO will have been heavily involved in coordinating the various strands of the investigation/assessment processes. It is therefore recommended that consideration be given to commissioning an independent chair for the case conference and any establishment case conferences. (This may be a manager/senior manager from another locality or team).

Practical issues to be considered prior to the meeting are:

- The agenda and who will chair the meeting? This will normally be the DSO but it must be someone with authority to agree any necessary decisions taken during the meeting.
- Venue, date, and time.
- Minute taking arrangements.
- Who will be invited and in what capacity, and how this will be done.
  - Will all those invited be present during the whole meeting.
- Any arrangements necessary to assist the user/carers (access, interpretation, advocacy).

1. If the abuser is another service user a separate meeting should be considered to address the issues for them.
2. Everyone who has been victimised in this case or by this perpetrator should at least be represented at the conference. This will enable plans for treatment and/or support to be considered. If the conference is being held at an establishment level, the needs of all the named vulnerable adults must be taken into account.
3. It may be possible to consider the needs of the vulnerable adult and their carer(s) in the same conference, but be aware of their distinct, and sometimes conflicting, needs. They should be considered separately on the agenda.
4. Issues of confidentiality must be considered carefully before the conference. Boundaries will need to be kept around separate issues. (The vulnerable adult and his/her carers should not be present when action against a member of staff or service is discussed or other confidential information is disclosed).
5. If the investigation indicates that a service provider is culpable, an establishment case conference should be arranged with them, to take place after the case conference for the service user(s). The regulatory authorities and/or commissioning might take a significant role in this case conference.
   The DSO and representatives from other funding agencies may attend to represent service users and commissioning agencies.
6. If a KCC/Medway establishment is culpable an internal review meeting should be held separately.
7. The service provider must be informed at least 48 hours prior to the establishment case conference or internal meeting about the issues likely to be raised. This will enable them to consider how they may be able to respond.
The Chair should:

a. Ensure that all-relevant people and professionals involved with the care of the vulnerable adult(s) are represented at the conference.

b. Circulate relevant information to the participants in advance, marked 'highly confidential' where this is feasible and appropriate.

c. Ensure that the status of the case conference and the reasons for it taking place are explained to the vulnerable adult(s) and his/her representative(s) prior to the conference to enable them to make a decision regarding their attendance. The completed reports from the investigation should be discussed with the victim and/or their representative at this stage.

d. Ensure that the vulnerable victim is at the centre of the discussions. There should be no decisions made about the post-abuse support needs of the victim without their full involvement or the involvement of their representative(s). Therefore, the Chairperson has authority, in consultation with the vulnerable adult and other representatives, to restrict or exclude attendance of people at the conference. This should be clearly recorded in case conference notes.

e. Arrange for accurate minute taking to be carried out and assistance with other administrative tasks.

f. Present a brief background of the case and explain the main aims of the case conference: this should be followed by a statement of facts and details by the investigating officer in the form of a short report.

g. Facilitate full discussion of the facts and opinions in order to jointly establish the status of the allegations. The outcome of this discussion must be clearly recorded in the minutes of the meeting. This must include a decision regarding the outcome of the investigation/assessment. Was the abuse confirmed, was the person abused (harmed) by the actions or omissions or another(s) regardless of any intent. Were elements of the allegations confirmed, was abuse discounted or was there insufficient evidence to determine if abuse occurred.

h. Formulate a clearly defined safeguarding plan and a mechanism for ongoing support and service arrangements for the vulnerable adult(s). Ensure that the vulnerable adult(s) is involved in formulating the care plan.

i. Facilitate discussion regarding the possible risk to other vulnerable adults and formulate a plan to reduce or remove the risk, in liaison with other agencies.

j. Draw up a post abuse care plan, which documents any:

   - Ongoing risk and measures to be taken to prevent further abuse. In a domestic situation where there is an ongoing risk of serious harm to the vulnerable adult a Multi Agency Risk Assessment Conference (MARAC) may be considered to ensure that all agencies are fully engaged in preventing further harm.

   - Additional services or therapeutic interventions and/or changes in service provision or daily routines, legal support, advocacy for the vulnerable adult(s) e.g. for compensation.

   - Indicators which should trigger a review and/or further investigations.

   - Crucial times/events such as court cases, release from custody, disciplinary hearings which might lead to further precautions becoming necessary.

   - Review and monitoring arrangements to ensure that the safeguarding care plan is effectively implemented specifying by whom each task is to be carried out, within what time-scale and which manager is accountable.

k. In a separate section of the meeting, agree what recommendations will be made in relation to the person(s) responsible for the abuse and the setting.
l Summarise the whole discussion and outcome of the conference and arrange a date for reviewing the arrangements made to protect and support the vulnerable adult(s). The nature and frequency of monitoring and reviews will vary in each case. Care should be taken to establish who will monitor outstanding issues and processes such as bail hearings, court cases, action under the Health and Social Care Act 2008, disciplinary hearings, tribunals or action by professional bodies, parole and release dates after prison sentences.

m Ensure the completion of the case conference documentation and place it on file with appropriate cross-references where several individuals are involved.

n Ensure that accurate minutes of the case conference are circulated to the invited persons on a 'need to know basis'. The chairperson also needs to agree in the conference what information should be passed on to other agencies, not represented at the meeting, on a 'need to know' basis. The meeting should also agree what feedback should be given to the referrer and by whom.

o Any disagreements regarding the recommendations from the conference should be recorded and discussed with a senior manager as a matter of urgency.

p At the conclusion of the case conference the DSO/Chair should ensure that relevant information is recorded to enable the completion of the statistical monitoring.

q The DSO should ensure that the appropriate adult protection paperwork is completed. This should include the alert/referral form and preparing the closure summary/form to include a record of any post abuse work necessary. This must be signed off by the Senior/service manager.

The adult protection case papers should be filed in the closed section of the vulnerable adult's file.

If the case has been co-ordinated by a host locality/authority they should retain the original adult protection case papers and pass a copy to the placing locality/authority to be placed in the closed section of the client's case file.
Adult Protection Post Abuse Checklist

Adult protection alerts can result in a variety of actions that affect the victim(s), alleged perpetrator, service or setting, families and/or carers. However the adult protection process was managed, much of the effectiveness of the work will be jeopardised, if post abuse issues are not considered. Any post abuse plans may have cost implications that need to be discussed and agreed by management. It is important that the people/agencies responsible for any part of the safeguarding care plan for the vulnerable adult(s) and action plans for services are clearly identified. The following points might assist in considering a post abuse plan and any actions/support work that may be required:

For the victim
a  Practical: domiciliary support, closer oversight/monitoring, alternative accommodation, day care, respite care, residential care, adaptations or aids, advocacy, medical treatment.

b  Emotional: victim support, psychology, counselling, therapy, psychiatric assessment and/or treatment.

c  Legal/Financial: money advice, legal advice re criminal/civil injury compensation, preparation for court. Is there a need for an appointee/receiver? Is referral to the Office of the Public Guardian appropriate?

d  Educational: training in assertiveness, sexuality and relationships, and social skills; understanding what constitutes abuse and protective measures for the future, to understand the implications of making unfounded accusations.

For the perpetrator (if a carer or staff member or informal carer)

a  Practical: domiciliary, respite or day care, vulnerable adult to move to alternative accommodation, adaptations/aids, help with housing, closer monitoring/supervision, medical treatment.

b  Emotional: group support (e.g. carer's group), counselling, psychiatric/psychological input. Support especially from employers if they have been wrongly accused of abuse.

c  Legal/Financial: legal advice services, money advice/debt counselling.

d  Educational: training to consider the values involved in caring, training to develop practical caring skills (e.g. moving and handling, first aid), training to understand about issues of abuse, training in responding to difficult behaviour.

Other steps may be taken against the perpetrator, which could include: Prosecution, disciplinary action, removal from a professional register, referral to the Disclosure and Barring Service (under the Care Standards Act), action under the Mental Health Act.

For the perpetrator (if another service user)

a  Practical: domiciliary support, respite or day care, longer term residential care, additional/closer monitoring and or supervision, alternative accommodation, adaptations/aids, help with housing.

b  Emotional: group support, counselling, advocacy, psychiatric/psychological input. Special support if they have been wrongly accused of abuse.

c  Legal/Financial: legal advice, money advice / debt counselling.

d  Educational: sexuality and relationships training, understanding about issues of abuse, support to develop social skills.

Other steps may be taken against a perpetrator who is also vulnerable and may be a service user. These include prosecution or action under the Mental Health Act. Both of these will probably require input from mental health services and or psychological services to determine an appropriate course of action.

Amended July 2013
**For the service/setting**

Where a service or setting is responsible or implicated in abuse of a vulnerable adult(s), it will be important to consider what actions are appropriate to ensure the safety and good care of other service users. This should be done during an establishment case conference or an internal service review meeting. The meeting should agree a 'service action plan' which may include any of the following:

a. Recommendation to close the home/service by the regulatory authorities.

b. Advice/notice to the service to make changes. Support/advice from commissioning or care management.

c. Close and recorded monitoring of the service by regulatory authorities.

d. Audit of the service by commissioning staff, followed by written requirements for improvements and/or changes and close monitoring.

e. Informing other local authorities of an outline of the issues investigated and the outcomes.

**To Summarise**

Where any actions are included in the post abuse plan for the victim or a vulnerable perpetrator or post abuse action plan for the service/setting, it is important that these actions are monitored, reviewed and recorded. At any time the managers responsible for ensuring actions are taken (care management, regulatory or commissioning) may call a case conference/establishment conference or service review meeting, if it appears that appropriate actions are not being followed or that there is an increased risk of abuse to one or more vulnerable adults.
Manager's Checklist

The designated senior officer (DSO) may be the locality head of service, assistant director, service manager, team leader/manager, safeguarding adults co-ordinator or senior practitioner. The head of service /assistant director or service manager retains ultimate responsibility for decision-making.

As the DSO you are responsible for the overall co-ordination and management of an adult protection case and chairing any meetings which may be necessary.

You should delegate the task of investigation/assessment to an appropriately trained and experienced staff member who will report back to you. This person will be referred to as the investigating officer. You will need to be available to provide support, supervision and advice to the investigating officer and ensure that they have the resources necessary to carry out their task. (Resources include time, clerical support and another person with whom to share the task of interviewing).

Details of your responsibilities throughout the process of alerting, planning, investigation, case conferencing and post abuse work are included in the process checklists.

As the DSO your overall responsibilities include:

a) Receiving initial adult protection documentation, evaluating information and considering initial risk assessment, managing consultation with other agencies and authorising emergency action to protect the vulnerable adult(s) if this is indicated from the information available.

b) Ensuring that the wishes and views of the vulnerable adult regarding the allegation are ascertained and recorded. If the vulnerable adult appears to lack mental capacity or is unable to express their wishes and views ensure that an advocate is involved to support them. The SA1 form will assist you in recording this information.

c) Ensuring that where the mental capacity of the vulnerable adult is in doubt; an appropriate mental capacity assessment is carried out and recorded.

d) Ensuring that where the vulnerable adult lacks mental capacity to make decisions regarding the alleged abuse and any actions that may be needed, a check is made to ascertain if anyone has a Deputy or a registered Lasting Power of Attorney (LPA) for health and welfare. If not then an IMCA may needed.

e) Ensuring a formal referral is made to children and families where any possible risk to children is identified.

f) Ensuring that there is a completed alert/referral form on the file and that the information has been input onto the AP database.

gh) Liaising with the commissioning, where appropriate, regarding the status of the contract and deciding with them whether any action is needed in relation to the contract, either before, during or after the investigation or case conference has taken place.

i) Liaising with CQC and police, where appropriate, to ensure their full involvement.

j) Chairing planning/strategy meeting, case conferences and reviews.

k) Ensuring that any discriminatory issues are addressed.

l) Ensuring that, where appropriate, placing authorities are informed of adult protection issues of concern in a care home or day care setting that might affect their clients. This will enable them to be involved in meetings and assessments as necessary.

m) Ensuring that a complete record of all contacts, meetings, phone calls, interviews and decisions are kept in the closed/restricted part of the client's file.
m) The DSO in consultation with other professionals may, at any time in the adult protection process, decide that the issues have been addressed. They must ensure that all-relevant people and/or agencies are made aware of this decision, including the vulnerable adult, family, carer(s) and the referrer. The reasons for the decision must be recorded on the summary/closure form and the assistant director/locality head of service/service manager/team manager will be responsible for signing off the case. If the vulnerable adult, family, carer(s) or any professionals have concerns about this decision they should record their concerns, in writing. The assistant director/locality head of service or service manager should inform senior management of any disagreement with the decision taken.

n) Ensuring that the decisions taken as a result of consultations with other agencies or departments or during a formal planning/strategy meeting or informal planning discussions are recorded.

o) Ensuring that any assessment/investigation carried out with or without the support of other agencies is fully recorded and that there is a written summary of the findings on which to base decisions.

p) Ensuring that decisions taken, at planning/strategy meetings or case conferences, are appropriately minuted including decisions about: the vulnerable adult(s); the person responsible; the service setting/agency.

q) Ensuring that the minutes of meetings are circulated to those participating in or invited to the meeting. Deciding what information will be made available to the employer or other agencies to enable them to carry out their statutory obligations.

r) Ensuring that a post abuse plan is agreed and recorded in the vulnerable adult's file.

s) Ensuring that any disagreement with recommendations taken at meetings is recorded and discussed with a senior manager as a matter of urgency.

t) Ensuring that a named staff member is delegated to monitor and review the 'post abuse support/care plan, agree the timescale for this': agree any triggers that indicate an urgent review meeting should be called.

u) Supporting where appropriate an establishment case conference or internal review meeting. Ensuring a named staff member is delegated to monitor and review within an agreed timescale the 'service action plans' to ensure that the service provides 'safe' care.

v) Ensuring that, where appropriate, post abuse support/counselling is available and funded to enable the client(s) to recover from the abuse or deal with any issues which continue to cause them or their carers concern.

w) Ensuring appropriate feedback is given to all relevant people and agencies, including the referrer.

x) Ensuring that any innocent ‘whistle-blowers’ are not inappropriately penalised by their action(s). If necessary writing a brief letter, to give to them or future employers, to record and commend their action in supporting the protection of vulnerable adult(s).

y) Ensuring that the case is signed off and monitored and reviewed using agreed documentation.

z) Ensuring that the AP case papers contain a full and accurate record of the work carried out in relation to the concerns and that the case papers are filed in the closed section of the clients file. If the case has been co-ordinated by a host locality/authority they should retain the original adult protection case papers and pass a copy to the placing locality/authority to be placed in the closed section of the client's case file.

aa) Where an inquest or court case is likely the DSO must alert senior managers in all agencies involved in the case. It is the responsibility of these senior managers to consider accessing legal advice/support for all potential witnesses from their organisation/service. It is also recommended that witnesses have appropriate management and pastoral support when attending court.

bb) Ensuring that appropriate multi-agency debriefing takes place for staff who have worked with complex and distressing cases.
Suggested Agenda for an Adult Protection Establishment Case Conference/Internal Review Meeting

At least **48 hours prior to this meeting** the establishment concerned should have been provided with an outline of the issues to be addressed.

This meeting will focus on the outcomes of the adult protection investigation/assessment from the perspective of the service provider. The meeting may be chaired by a senior manager from the commissioning or care/case management.

Any meeting focusing on the vulnerable adult(s) should have been completed prior to this meeting.

1 **Introductions**
   - Status of and reason for calling the meeting.
   - Structure of the meeting.
   - Rules of the meeting (including confidentiality and equal opportunities statements).
   - Reason for any delay in convening the meeting.

2 **Background**
   - Outline of the initial cause for concern regarding abuse or possible abuse.
   - Summary of the outcome of the investigations with regard to the service provision.
   - Vulnerable adult(s)/family response to the outcome of the investigation.
   - Any formal/legal action proposed by the vulnerable adult(s)/family.
   - Any actions proposed/accepted by the vulnerable adult(s)/family to resolve issues.

3 **Outline of concerns**
   - Ongoing concerns regarding the service.

4 **Service response**
   - Invite the service to respond to the issues raised.

5 **Chair summarises the outcome and recommendations following discussions.**

6 **Action to be taken by the service.**

7 **Actions to be taken by commissioning/CQC/care/case management.**

8 **Monitoring/reviewing arrangements for the service action plan and agreed timescales.**

9 **Date, time and venue of any review meeting agreed.**
Seriousness of the Abuse

This section is designed to assist in the assessment of the seriousness of the abuse, its impact and the risk of it being repeated. Seriousness is broken down into 8 elements that should be considered separately by marking a point on each scale where the left is less serious and the right hand end is most serious.

The 8 elements are:

- The extent of the abusive act(s)
- Whether the abuse was a one off event or part of a longstanding relationship or pattern
- The impact of the abuse on the vulnerable adult
- The impact of the abuse on other vulnerable adults or children
- The intent of the person alleged responsible for the abuse
- The illegality of the alleged perpetrators action(s)
- The risk of the abuse being repeated against this vulnerable adult
- The risk of the abuse being repeated against other vulnerable adults or children
1 The Extent of the Abusive Act(s)

Judge the extent of the act(s) using the following grid as a rough guide, but also using your own professional judgement.

**Type of Abuse**

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Physical</th>
<th>Sexual</th>
<th>Psychological</th>
<th>Financial/Material</th>
<th>Neglect</th>
<th>Discriminatory (based on all possible areas of difference)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>bruising</td>
<td>non contact abuse including verbal harassment</td>
<td>occasional teasing, taunts or verbal outbursts</td>
<td>petty cash fiddled</td>
<td>lack of care leads to discomfort or inconvenience such as being left wet occasionally</td>
<td>occasional harassment or slurs related to issues of difference</td>
</tr>
<tr>
<td></td>
<td>lesions</td>
<td>sexual touch</td>
<td>frequent verbal outbursts</td>
<td>belongings taken</td>
<td>lack of care to extent that bedsores or other medical complications develop</td>
<td>having difficulty getting access to services</td>
</tr>
<tr>
<td></td>
<td>assault requiring attendance at casualty or other medical treatment</td>
<td>masturbation</td>
<td>humiliation and threats on a regular basis</td>
<td>no control of personal finances</td>
<td>ongoing neglect such as causes malnutrition or other illness</td>
<td>being refused access to services or essential support</td>
</tr>
<tr>
<td></td>
<td>assault with weapon and/or leading to irreversible damage</td>
<td>attempted penetration</td>
<td>vicious and personalised attacks</td>
<td>fraud, of property or wills</td>
<td>failure to access life saving services or medical care</td>
<td>being taunted, harassed and threatened leading to fears for safety</td>
</tr>
<tr>
<td></td>
<td>grievous bodily harm or attempted murder</td>
<td>rape</td>
<td>repeated verbal assaults, threats and intimidation</td>
<td>fraud to extent that person risks destitution</td>
<td>neglect of medication or psychological needs leading to fear for survival or death</td>
<td>hate crime result in injury or fear for life</td>
</tr>
</tbody>
</table>

**Serious**

- 

- 

- 

**Extremely Serious**

- 

- 

- 


2 Whether the abuse was a one-off event or part of a longstanding relationship or pattern

- Isolated incident
- Repeated abuse in an ongoing relationship
- Repeated abuse which has gone on for over 12 months

Serious | Extremely serious

3 The impact of the abuse on the physical and/or mental health of the alleged victim

- Short term (Can take in their stride)
- Lasting distress or injury
- Potentially life threatening

Serious | Extremely serious

4 The impact on others, e.g. children, other relatives or residents/service users

- No-one else involved or witnessing abuse
- Others relatives/residents are disturbed/distressed about or the abuse
- Others are seriously intimidated and/or their environment distorted

Serious | Extremely serious

5 The intent of the person alleged to be responsible for the abuse

- Inadvertent or ill informed
- Violent/serious unprofessional response to difficulties in caring
- Planned and deliberately malicious

Serious | Extremely serious

6 The illegality of the alleged perpetrator's action(s)

- Poor or bad practice but not illegal
- Maybe against the law
- Clearly a criminal offence

Serious | Extremely serious
7. The risk of the abuse being repeated against this adult client

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very unlikely</td>
<td>Not if significant changes are made e.g. training, supervision, respite or support</td>
</tr>
<tr>
<td>Very likely even if changes are made and/or more support provided</td>
<td></td>
</tr>
</tbody>
</table>

Serious | Extremely serious

8. The risk that abuse will be repeated against other vulnerable adults or children

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, very unlikely</td>
<td>This perpetrator/setting may change but supervision/training needed</td>
</tr>
<tr>
<td>This alleged perpetrator/setting represents a threat to other vulnerable adults or children</td>
<td></td>
</tr>
</tbody>
</table>

Serious | Extremely serious

Now look back and ring all the aspects of seriousness where you have marked the line towards the right hand end - these represent very serious issues which you must take into account in your decisions and risk management strategy. You may want to share your thinking with the case conference whether verbally or in your report.
Safeguarding Vulnerable Groups Act 2006
As amended by the Protection of Freedoms Act 2012.

Disclosure and Barring Service (formally ISA)

From December 2012 the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) will merge into the Disclosure and Barring Service (DBS). This new service will provide a joined up, seamless service to combine the criminal records and barring functions. Further changes will come into force during 2013 and 2014. Details will be published on the DBS website.

The ISA referral guidelines were published on 27th September 2009. They came into force from 12th October 2009. The power/duty to refer information to ISA is under the Safeguarding Vulnerable Groups Act 2006. To assist in understanding the referral process the ISA published a guidance document and a referral form which should be used when making a referral to the ISA.

Concerns were expressed by the government and the public that the responsibilities for protecting children and vulnerable adults under the SGVG Act 2006 was focused too much on the State and not sufficiently on employers, voluntary organisations and charities. The government has scaled back the criminal records and barring systems to more proportionate levels. The changes to the systems were included on the Protection of Freedoms Act 2012. The changes are being implemented incrementally but from September 2012 the following changes were made.

- New definition of regulated activity.
- Repeal of controlled activity.
- Repeal of registration and continuous monitoring.
- Repeal of additional information.
- Minimum age (16) at which someone can apply for a CRB check.
- More rigorous ‘relevancy’ test for when the police release information held locally on an enhanced CRB check.

The following elements are not changing:

- The Employer or Volunteer Coordinator must make appropriate referrals to the ISA. (from December 2012 the local authority has the power rather than the duty to refer to the DBS)
- The Employer or Volunteer Coordinator must not engage in regulated activity someone whom you know has been barred by the DBS.

Everybody within the pre-September 2012 definition of regulated activity will remain eligible for enhanced CRB checks, whether or not they fall within the post-September definition of regulated activity.

The referral guidance documents and the referral form are subject to revision and updating so you are advised to access the up to date versions of the guidance and the form direct from the DBS website.

The guidance sets out:

- the key elements of the referral process
- the circumstances under which a referral should be made
- the legal responsibilities of employers, including the paid and voluntary sector and also employees.
- The responsibilities of Local Authorities, Keepers of Registers and Supervisory Authorities and Health and Social Care Bodies
- the main points of the law in relation to referrals
Definitions of Key terms used within the guidance can be found in section 4 of the guidance.

**DBS Referral Guidance**

This duty to share information was introduced under the Vetting and Barring Scheme. From 12th October 2009 employers, social services and professional regulators have to notify the ISA of relevant information so that individuals who pose a threat to vulnerable groups can be identified and barred from working with these groups. *(From December 2012 the local authority has the power rather than the duty to refer to the DBS)*

Referral to the DBS must be made when *relevant conduct* has occurred.

*Relevant Conduct* is that which:
- Endangers or harms a child or vulnerable adult or is likely to endanger or harm a child or vulnerable adult;
- If repeated against or in relation to a child or vulnerable adult, would endanger them or would be likely to endanger them;
- That involves sexual material relating to children (including possession of such material);
- That involves sexually explicit images depicting violence against human beings (including possession of such images), if it appears to DBS that the conduct is inappropriate; or
- Of a sexual nature involving a child or vulnerable adult, if it appears to DBS that the conduct is inappropriate.

**The Responsibilities of Employers or Volunteer Coordinators**

The main responsibility for making a referral to the DBS rests with the regulated activity providers. They are employers or volunteer coordinators. They must make the referral when they withdraw a person from regulated activities or would have done so had the person not resigned, retired, been made redundant or been transferred to a non regulated or controlled activity. *(This does not apply to temporary suspension without prejudice pending investigation)*

**Definition of Regulated Activity Relating to Adults (from September 2012)**

The definition of regulated activity relating to adults no longer labels adults as ‘vulnerable’. Instead, the definition identifies the activities which, if any adult requires them, lead to that adult being considered vulnerable at that particular time. This means that the focus is on the activities required by the adult and not on the setting in which the activity is received, nor on the personal characteristics or circumstances of the adult receiving the activities. There is also no longer a requirement for a person to do the activities a certain number of times before they are engaging in regulated activity.

There are six categories of people who will fall within the definition of regulated activity (and so will anyone who provides day to day management or supervision of those people). A broad outline of these categories is set out below. For more information please see the Safeguarding Vulnerable Groups Act 2006, as amended by the Protection of Freedoms Act 2012.

(i) Providing health care
Any health care professional providing health care to an adult, or anyone who provides health care to an adult under the direction or supervision of a health care professional. Please see the Safeguarding Vulnerable Groups Act 2006, as amended by the Protection of Freedoms Act 2012, for further details about what is meant by health care and health care professionals.

(ii) Providing personal care
Anyone who:
- provides physical assistance with eating or drinking, going to the toilet, washing or bathing, dressing, oral care or care of the skin, hair or nails because of an adult’s age, illness or disability;
• prompts and then supervises an adult who, because of their age, illness or disability, cannot make the decision to eat or drink, go to the toilet, wash or bathe, get dressed or care for their mouth, skin, hair or nails without that prompting or supervision; or
• trains, instructs or offers advice or guidance which relates to eating or drinking, going to the toilet, washing or bathing, dressing, oral care or care of the skin, hair or nails to adults who need it because of their age, illness or disability.

(iii) Providing social work
The provision by a social care worker of social work which is required in connection with any health care or social services to an adult who is a client or potential client.

(iv) Assistance with cash, bills and/or shopping
The provision of assistance to an adult because of their age, illness or disability, if that includes managing the person’s cash, paying their bills or shopping on their behalf.

(v) Assistance in the conduct of a person’s own affairs
Anyone who provides various forms of assistance in the conduct of an adult’s own affairs, for example by virtue of an enduring power of attorney. Please see the Safeguarding Vulnerable Groups Act 2006, as amended by the Protection of Freedoms Act 2012, for the further categories which are covered here.

(vi) Conveying
A person who transports an adult because of their age, illness or disability either to or from their place of residence and a place where they have received, or will be receiving, health care, personal care or social care; or between places where they have received or will be receiving health care, personal care or social care. This will not include family and friends or taxi drivers.

Withdrawal from Regulated Activity
Withdrawing a person from regulated activity in the context of making a referral does not necessarily mean permanently removing them. Once your investigations have established harm or risk of harm to a child or vulnerable adult a decision needs to be made as to the best way of managing this information.
1. Return the individual to work with additional training and / or a warning
2. Dismiss the individual
3. Return the individual to a non regulated activity
4. Continue suspension due to risk of harm while seeking advice

If the decision is to remove the person either through points 2 to 4 above then permission to engage in regulated activity has been withdrawn and referral to the DBS must be made.

• Where an individual has left your employ before you made any final disciplinary decision due to harm or risk of harm to a vulnerable adult this information must also be referred to the DBS

Responsibilities of Local Authorities Keepers of Registers, Supervisory Authorities, Health and Social Care (HSC) Bodies and Education and Library Boards.

In all cases the trigger to make a referral to the DBS is when there is evidence that an individual who is engaged or may have been engaged in regulated activity has:

• engaged in Relevant Conduct;
• satisfied the Harm Test (see section 30a)

or received a caution or conviction for a relevant offence.

• and they consider that the DBS may bar the worker

If the above conditions have been met the prescribed information must be referred to the DBS by the employer or the volunteer coordinator.
The referral should be made to the DBS when the body (employer or volunteer coordinator) has gathered sufficient evidence as part of their investigations to support their thinking that a person has engaged in relevant conduct, satisfied the harm test or received a caution or conviction for a relevant offence. At this point the body should think the person has a case to answer. Referral at this point will help to ensure that the DBS has sufficient evidence to commence its decision making process while providing adequate safeguarding for vulnerable groups.

All Groups: Making a Referral When There Is No Duty to Refer

The DBS will consider all information referred to it from any source in relation to whether an individual should be included in a barred list. For example:

- Regulated activity providers and other groups may provide information where following an internal investigation there is insufficient evidence to show relevant conduct occurred, but they still have concerns about that individual; or
- Where an employer may have concerns about an individual who has left their employ and they know or think that the individual works in regulated activity in another setting.

Again there is no duty to refer to the DBS but they may.

Who Will Be Informed If An Individual Is Barred?

Following representations, if an individual is subsequently barred they will be notified in writing and they are Barred. All organisations with a legitimate interest in the individual will be notified that the individual is Barred. If the individual is not barred, they and legitimately interested parties will be advised in writing.

The DBS does not have the power to inform any other individuals or organisations of the decision including an employer who may have dismissed the individual (as they no longer have a legitimate interest in the individual).

A barred person is breaking the law if they seek, offer or engage in regulated activity with a group from which they are barred from working, be it paid or voluntary.

Legitimate Interest

A person or organisation has a legitimate interest in another person if they
- have engaged or are considering engaging them in regulated activity, and
- the person or organisation has registered any interest and
- the registered interest relates to the activity that the person or organisation has permitted the individual to engage in and
- the person or organisation has notified the DBS of the address to which any notification is to be sent or
- if they are a Keeper of Register or Supervisory body as mentioned in the 2006 Act or 2007 Order and the individual concerned is registered with that body.

It will be apparent from this information that neither the ex-employer nor local authority that made the referral to the DBS will be informed of the outcome of the referral. So the records held by the employer and the local authority will be a record that a referral was made by to the DBS in respect of the individual.

Those with a duty or power to refer should send new referrals to the following address:
Disclosure and Barring Service
PO Box 181, DARLINGTON DL1 9FA

The DBS Referral Guidance and referral form are now available on: DBS Referral Form and Guidance
### Examples of Types of Harm to a Vulnerable Adult

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Definition of Abuse</th>
<th>Examples of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional / Psychological</td>
<td>Action or inaction by others that might cause mental anguish</td>
<td>Inflexible regimes and lack of choice. Mocking, coercing, denying privacy, threatening behaviour, bullying, intimidation, harassment, deliberate isolation, deprivation.</td>
</tr>
<tr>
<td>Financial</td>
<td>Usually associated with the misuse of money, valuables or property</td>
<td>Unauthorised withdrawals from vulnerable adults account, theft, fraud, exploitation, pressure in connection with wills or inheritance.</td>
</tr>
<tr>
<td>Physical</td>
<td>Any physical action or inaction that results in discomfort, pain or injury.</td>
<td>Hitting, slapping, pushing, shaking, bruising, failing to treat sores or wounds, under or overuse or medication, un-prescribed or inappropriate medication, use of restraint or inappropriate restraint, inappropriate sanctions.</td>
</tr>
<tr>
<td>Sexual</td>
<td>Coercion or force to take part in sexual acts.</td>
<td>Inappropriate touching. Causing bruising or injury to the anal, genital or abdominal or oral area. Transmission of STD.</td>
</tr>
<tr>
<td>Neglect</td>
<td>Failure to identify and/or meet care needs.</td>
<td>Untreated weight loss, failing to administer reasonable care resulting in pressure sores or uncharacteristic problems with continence. Poor hygiene, soiled clothes not changed, insufficient food or drink, ignoring resident’s requests, unmet social or care needs.</td>
</tr>
<tr>
<td>Verbal</td>
<td>Any remark or comment by others that causes distress.</td>
<td>Demeaning, disrespectful, humiliating, racist, sexist, or sarcastic comments. Excessive or unwanted familiarity, shouting, swearing, name calling.</td>
</tr>
</tbody>
</table>

Guidance notes for the Barring Decision Making Process. (ISA February 2009)
Audit Tool for Evaluation of Individual Abuse Alerts

This tool has been developed to enable managers in all agencies/services to evaluate the effectiveness of the adult protection process and outcomes for service users, carers and professionals.

Client ID/name____________________________________ Date of Alert______/_____/_____
Locality/service involved in addressing the alert_____________________________________

<table>
<thead>
<tr>
<th>Adult protection protocol</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Referral process</td>
<td></td>
</tr>
<tr>
<td>a Was the referral received appropriately?</td>
<td></td>
</tr>
<tr>
<td>b Was the referral made at the right time?</td>
<td></td>
</tr>
<tr>
<td>c Were any problems encountered during this part of the process?</td>
<td></td>
</tr>
<tr>
<td>d Was the response to the referral quick enough?</td>
<td></td>
</tr>
<tr>
<td>e Was the safety of the client addressed?</td>
<td></td>
</tr>
<tr>
<td>2 Discussion with line manager</td>
<td></td>
</tr>
<tr>
<td>a Was a line manager accessible?</td>
<td></td>
</tr>
<tr>
<td>b Was a grandparent manager accessible in line manager’s absence?</td>
<td></td>
</tr>
<tr>
<td>c Did lack of access to a line manager/grandparent manager affect the ability to keep within time constraints?</td>
<td></td>
</tr>
<tr>
<td>3 Police involvement-where appropriate</td>
<td></td>
</tr>
<tr>
<td>a Was the response from the police appropriate?</td>
<td></td>
</tr>
<tr>
<td>b Was advice given when requested?</td>
<td></td>
</tr>
<tr>
<td>c Did they attend planning/strategy meeting if requested?</td>
<td></td>
</tr>
<tr>
<td>d Did they support an investigation if requested?</td>
<td></td>
</tr>
<tr>
<td>e Did they attend case conference if requested?</td>
<td></td>
</tr>
<tr>
<td>4 Health involvement-where appropriate</td>
<td></td>
</tr>
<tr>
<td>a Was the response from health appropriate?</td>
<td></td>
</tr>
<tr>
<td>b Did a representative attend a planning/strategy meeting if requested?</td>
<td></td>
</tr>
<tr>
<td>c Did a representative support an investigation/assessment if requested?</td>
<td></td>
</tr>
<tr>
<td>d Did a representative attend a case conference if requested?</td>
<td></td>
</tr>
<tr>
<td>5 Planning/strategy meeting/discussion</td>
<td></td>
</tr>
<tr>
<td>a Did this take place within 48 hours following receipt of referral?</td>
<td></td>
</tr>
<tr>
<td>b Were there any difficulties/delays in arranging this?</td>
<td></td>
</tr>
<tr>
<td>c Did all relevant agencies take part?</td>
<td></td>
</tr>
<tr>
<td>d Was a plan of investigation agreed?</td>
<td></td>
</tr>
<tr>
<td>e Was an investigation officer(s) identified?</td>
<td></td>
</tr>
<tr>
<td>6 Investigation</td>
<td></td>
</tr>
<tr>
<td>a Did this commence ASAP after the planning/strategy meeting/discussion?</td>
<td></td>
</tr>
<tr>
<td>b Were all agencies kept informed?</td>
<td></td>
</tr>
<tr>
<td>c Did a subsequent case conference take place?</td>
<td></td>
</tr>
<tr>
<td>d Was a post abuse care plan put in place to protect the vulnerable adult?</td>
<td></td>
</tr>
</tbody>
</table>
### 7 Monitoring

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Was the alert information entered onto the system within 48 hours?</td>
</tr>
<tr>
<td>b</td>
<td>Was the monitoring data entered as soon as the case was signed off?</td>
</tr>
<tr>
<td>c</td>
<td>Was the adult protection referral closed?</td>
</tr>
<tr>
<td>d</td>
<td>Did the adult protection referral remain open because the victim remained at risk?</td>
</tr>
</tbody>
</table>

### 8 Alleged victim's, carer's and providers satisfaction

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Was the victim satisfied with the investigation process?</td>
</tr>
<tr>
<td>b</td>
<td>Was the victim satisfied with the outcome?</td>
</tr>
<tr>
<td>c</td>
<td>Was the carer satisfied with the investigation process?</td>
</tr>
<tr>
<td>d</td>
<td>Was the carer satisfied with the outcome?</td>
</tr>
<tr>
<td>e</td>
<td>Was the service provider satisfied with the investigation process?</td>
</tr>
<tr>
<td>f</td>
<td>Was the service provider satisfied with the outcome?</td>
</tr>
</tbody>
</table>

### 9 Significant issues

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>List the strengths and weaknesses of this investigation/assessment:</td>
</tr>
<tr>
<td>b</td>
<td>List any training needs highlighted by this investigation/assessment:</td>
</tr>
<tr>
<td>c</td>
<td>List any required changes to the investigation/assessment procedure highlighted by this investigation:</td>
</tr>
<tr>
<td>d</td>
<td>List any required changes to the overall process identified as a result of addressing this case. (use a separate sheet to provide any further details if necessary)</td>
</tr>
</tbody>
</table>

If problems were encountered in addressing this case consider whether the issues need to be passed to:

- The adult protection policy manager
- A safeguarding adults co-ordinator
- A locality head of service/service manager
- The head of adult services, assistant director
- Chair (Deputy) of the adult protection Board
- Adult protection lead manager

<table>
<thead>
<tr>
<th></th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The adult protection policy manager</td>
<td>○ Yes / ○ No</td>
</tr>
<tr>
<td>A safeguarding adults co-ordinator</td>
<td>○ Yes / ○ No</td>
</tr>
<tr>
<td>A locality head of service/service manager</td>
<td>○ Yes / ○ No</td>
</tr>
<tr>
<td>The head of adult services, assistant director</td>
<td>○ Yes / ○ No</td>
</tr>
<tr>
<td>Chair (Deputy) of the adult protection Board</td>
<td>○ Yes / ○ No</td>
</tr>
<tr>
<td>Adult protection lead manager</td>
<td>○ Yes / ○ No</td>
</tr>
</tbody>
</table>

If this form has been completed by someone who does not have social services responsibilities please record who the form has been passed to within your organisation

---

**Name of the person completing this form**

**Role of the person completing this form**

**Agency of the person completing this form**

**Date of the completion of this form**
Body Map

Client/patient name: Date of birth: Case number:
Address:

Right  Left  Left  Right

Please mark on these body maps any bruising/friction marks, burns etc. that the alerter may have seen on the body of the adult client, giving rise to the alert. In many cases of physical abuse, injuries are often explained as being accidental but if they are evident in soft parts of the body i.e. under arms, stomach, genitals or inner thighs, they are unlikely to have occurred as the result of a fall.

Please describe injury(ies)

Date: Time: Name of person completing this form:
Signature: Position:
Good practice guidelines for organising and managing adult protection meetings/case conferences

Designated Senior Officer Responsibilities

Preparation

- Give the admin officer as much notice as possible of all adult protection meetings.
- Ensure that there is an appropriately trained and skilled minute taker for the meeting.
- Provide options for dates and venues.
- Ensure that the admin officer arranging the meeting is informed about the nature of the meeting. Is it a planning/strategy meeting, a case conference an establishment meeting or a post abuse review meeting? How urgent is it?
- Give the admin officer a full list of the people to invite and what agencies they represent. E.g. SSD staff including commissioning staff, health, police, CQC, provider, advocate. Clarify who is essential to enable the meeting to take place.
- If different people are to be present during separate sections of the meeting ensure that sufficient time is allowed for discussions, to avoid attendees being kept waiting.
- Make appropriate accommodation and refreshment arrangements for people who are not attending the whole meeting. Ensure suitable arrangements are in place to alert the chair of the meeting to the arrival of additional participants.
- Ensure that the minute taker is prepared for the meeting by providing details of the nature of the alleged abuse and any matters likely to be discussed.
- The minute taker should be advised if there are any whistleblowers who wish to remain anonymous. Their names should be anonymised for the purposes of the meeting/minutes. (If any criminal or civil proceedings follow, the whistleblower(s) will be identified to the courts or other civil proceedings).
- Prepare an agenda for the meeting to enable the minute taker to understand how the meeting will be structured. The Aide-Memoire in AP guidance section 23 may assist with setting the agenda. Section 28 may assist if the meeting/case conference is to focus on provider service responses to a case.
- Consider the minute taker in arrangements particularly in relation to travelling time and transport arrangements. If the meeting is away from the minute takers normal base ensure that transport arrangements have been made.
- Ensure that all appropriate paperwork and any reports are passed to the admin officer. This will ensure that the adult protection alert is on the system and any papers needed for the meeting are copied and passed to the minute taker.
- Make sure that the minute taker is aware of any papers that need to be distributed during the meeting, read out at the meeting or subsequently summarised and distributed with the minutes.
- Be clear who will organise refreshments. Don't assume that the minute taker will do this.
- Ensure that appropriate support has been provided to any vulnerable adult (s) and his or her representative (s) prior to the meeting.
The Meeting

- Ensure that the minute taker sits next to you, that they have adequate space and suitable chair and writing area.
- Make sure that the attendance sheet with the confidentiality and equal opportunities statements is circulated before the main business of the meeting is discussed. The two statements must be read out at the start of the meeting.
- Ensure that the minute taker is introduced as part of the meeting and that they are aware of the names of all those present and, where relevant, the organisations they represent.
- Consider the pace of the meeting, make sure that only one person speaks at a time, try to keep to the agreed agenda and summarise at regular intervals.
- Make it clear that the minute taker can ask for clarification at any time during the meeting.
- Clarify any particular points you want minuted.
- If the meeting is lengthy or very difficult arrange for a short break if possible. This is important for the minute taker and essential if vulnerable adult(s) are present.
- You should summarise the agreed actions at the end of the meeting. Agree with the attendees if necessary to send out a copy of these as a priority.
- Check with the minute taker that any issues that need clarifying by attendees are addressed before the meeting closes.

After the Meeting

- Thank and debrief the minute taker immediately following the meeting. Discuss the format for the minutes and check if any clarification is needed, particularly in relation to any urgent action points that need to be circulated.
- If the minute taker is distressed about any issues discussed during the meeting ensure that they receive appropriate support.
- Make sure the minute taker is aware who should have the minutes or part of the minutes, and any reports.
- Where possible allow the minute taker allocated time away from normal duties to write up the draft minutes. If you are not the line manager for the minute taker liaise with the line manager to agree some protected time away from normal duties.
- When you receive the draft minutes, ensure that they are checked, amended and returned to the minute taker as soon as possible preferably within 5 working days.
- It is your responsibility to agree the final version of the minutes which will be placed in the client’s file. Please note that the names of the victims, vulnerable witnesses and vulnerable perpetrators must be replaced with initials only for all copies circulated.
- The distribution of minutes should be in line with Guidance Section 18 Managing Confidential Information in Documents, Reports and Minutes of Meetings.
- The action points from the meeting should be distributed within 2 working days of the meeting and the agreed minutes should be circulated within 10 working days unless exceptional circumstances make this impossible.
- Any matters arising from the minutes should be dealt with by you and not the minute taker.
- If future meetings related to this case are required, it may be helpful for the same minute taker to be available as they will be aware of the issues and many of the people involved in the case.
Good practice guidelines for organising and managing adult protection meetings/case conferences

Administrator's/minute taker’s responsibilities

Preparation

- If you are asked to arrange an adult protection meeting or take minutes you should have an understanding of the adult protection process. If possible you should have attended AP awareness training.

- You should have had an opportunity to attend minute takers training, when available. This training should be specifically designed for adult protection cases.

- If you have never minuted an AP meeting before discuss an induction with your line manager. This may include attending an AP meeting as an observer, then attending another in a supernumary capacity to practise minute taking.

- When asked to arrange any meeting related to adult protection make sure that you are aware of the type of meeting to be arranged and how urgent it is. It may be an initial or review planning/strategy meeting, case conference, establishment case conference or a post case monitoring and review meeting.

- Compile a list, in liaison with the Designated Senior Officer (DSO), of those who are essential to enable the meeting to go ahead and those who should be invited but who are not vital. Check availability by phone prior to sending out invitations.

- Discuss the agenda and structure of the meeting with the chair of the meeting or the DSO.

- Send out invitations by e-mail or letter. Service users/relatives should be sent a personalised invitation rather than the formal one.

- Ensure that a room has been booked at a suitable venue. Is disabled access, loop system or a translator required?

- If you have been asked to take the minutes of an AP meeting that is not at your normal work place, discuss travel arrangements to and from the venue with your line manager or the chair of the meeting.

- Familiarise yourself with the case and discuss with your line manager/ the chair of the meeting the main issues that are likely to arise.

- Prepare an attendance sheet with the confidentiality and equal opportunities statements at the top. List those people who have been invited and where appropriate the organisations they represent. If the meeting is divided with different participants attending separate parts of the meeting ensure that the attendance sheet(s) reflects this.

- Prepare a list of apologies and collate any reports, give to the chair of the meeting before the start of the meeting. Familiarise yourself with the contents of any reports as these will assist in compiling the minutes. If the reports are not circulated their contents can assist you to summarise the main issues.

- Advise reception staff of the meeting and the names of those attending and check that there are suitable waiting areas.

- You should provide paper and pens for participants.
• Consider providing name labels on the table to assist with communication and minute taking.

• Ensure that arrangements are in place for refreshments. Once the meeting begins, you should not be asked to leave the meeting unless a formal break is agreed or the meeting is closed.

• When arriving in the meeting room ensure that a space is available for you to sit next to the chair of the meeting. Discuss with the chair how you will gain their attention if necessary to clarify points or catch up.

The Meeting

• Sit next to the chair of the meeting.

• Don't be afraid to ask for clarification during the meeting.

• Ensure that everyone signs the attendance sheet on arrival.

• If name labels are being used make sure that you can see them. Otherwise familiarise yourself with the attendees and the organisations they represent.

• The formal minutes which will be placed in the clients file should be written in the past tense and all names should be typed in full.

• The names of whistleblower's who wish to remain anonymous at this stage should be anonymised. This should have been part of the pre meeting briefing.

• If any reports are tabled during the meeting ensure that you have a copy.

• It is important that the minutes accurately reflect the facts, concerns, risks, recommendations and action points. The discussions and decisions taken may lead to legal proceedings.

• Unless you take shorthand or the meeting is being tape-recorded it will not be possible for the minutes to reflect everything that is said. If you have been well briefed about the case before the meeting you will be aware of the important points.

• Listen carefully and record essential/ factual information.

• Separate facts from opinion.

• Write down key words; don't try to write down everything being said.

• Rely on the chair to advise you if an essential point needs to be noted.

• A lot of information will be repeated or not relevant to include in minutes.

• You may be able to develop your own form of speed writing.

• It is likely that some action points will be agreed at the meeting.

• Remember to ask for clarification if you need to. If it does not make sense in the meeting it is unlikely to when you come to write up the minutes.
After The Meeting

- Try to have a short de-brief with the chairperson immediately after the meeting.
- Ensure that no papers related to the meeting are left in the meeting room.
- Aim to produce a record of the action points which need to be agreed with the chairperson and then circulated to the attendees within 2 working days of the meeting.
- Aim to produce a full draft of the minutes as soon as possible after the meeting and pass them to the chairperson for approval. If the chairperson is not your line manager, agree with your line manager a timescale that reflects the urgency and priority that should be awarded to the task.
- If you are distressed by the content of the discussions during the meeting talk through the issues with the chair of the meeting or arrange to meet with your line manager to discuss the issues in confidence.
- The responsibility for the content of the minutes rests with the chair of the meeting and they rely on you to produce the draft and the final version of the minutes as soon as possible after the meeting has concluded. The file copy of the minutes must contain the full names of all professionals and vulnerable people involved.
- The copies of the minutes to be circulated should be adjusted to show only the initials of the victims, vulnerable witnesses and vulnerable perpetrators.
- Ensure that you know exactly who should have the minutes or part of the minutes and any additional papers that may have been agreed.
- The agreed adult protection minutes should be sent out within 10 working days of the meeting unless exceptional circumstances make this impossible. They should be sent either by secure e-mail or fax, or by recorded delivery.
- If another meeting has been discussed ensure that an appropriate meeting room is booked.
How the Social Service Agency May Respond to Adult Protection Concerns

Everyone has a responsibility to ensure that concerns about the abuse of vulnerable adults are addressed in a proportionate and timely manner. The lead responsibility for co-ordinating responses to adult protection concerns lies with the Social Services Agency (Social Services and the Mental Health Trust) although the government requires other organisations to work in partnership with them. Every reported incident of abuse, or suspected abuse, must be taken seriously and addressed with appropriate urgency. Service providers must complete an AP1 form (Appendices to this document) and contact the social services agency duty care management / social work team by telephone to report their concerns. A copy of the AP1 must be forwarded to the relevant team.

Whenever concerns about the abuse of a vulnerable adult are received by the Social Service Agency an Adult Protection alert/referral form must be completed for the vulnerable adult(s) involved. Initial assessment and evaluation of the available information must be carried out as a matter of urgency and a decision made about the most appropriate response. The following are possible responses that may be made at any stage in the adult protection process from initial consultation / formal referral to case conference:

- There is evidence of abuse but following assessment of the issues reported it appears more appropriate to address the situation in a less formal way e.g. through the provision of support services for a stressed carer.

- It does not appear to be abuse but an assessment of social care/support is instigated.

- It is abuse but the victim is not a vulnerable adult. Referral to a more appropriate service may be suggested e.g. police-combined safeguarding team or housing services.

- The concerns are of a general nature relating to poor standards of care in a regulated setting and referral to the regulatory authority and/or the commissioning team is more appropriate. (If their assessments identify the abuse of individual service users then adult protection referral(s) should be made).

- It is abuse, the alleged victim is a vulnerable adult and the formal adult protection process is followed.

- Initial assessment and evaluation of the concerns concludes that there is no evidence of abuse or abuse is discounted following investigation.

Framework for Responding to Adult Protection Concerns

This following framework may be used to assist managers and practitioners to determine the most appropriate level of response to an initial adult protection alert/referral of concern. It is designed as a tool to assist in the promotion of consistent decision making when an adult protection concern has been raised. It is not exhaustive and should be used as a prompt to effective decision making, not as a checklist or scorecard. It is also important that the level of response is kept under constant review, as additional information becomes available. This information may suggest that an alternative level of response is indicated because the perceived level of seriousness or risk has either increased or reduced. E.g. the decision to review the care package may result in further evidence that abuse is, or may be taking place.
### RESPONSE

**Level 1**

**Intervention by 'Service Providers’ indicated**

Adult protection concern reported to service provider

If the service provider reports the abuse concerns to the agency with social service responsibilities an \textit{alert/referral form must be completed} (this includes allegations of abuse in acute hospital settings). The service provider must report back the outcome of their assessment/investigation. Ongoing monitoring will usually be by the service provider in liaison with the care manager/social worker.

### PRESENTING INFORMATION

- 'one-off', isolated incident that has not adversely affected the physical, psychological or emotional well-being of the vulnerable adult
- no previous history of similar incidents recorded for the vulnerable adult
- no previous history of similar incidents recorded for the service provider
- no previous history of abuse by the person alleged to be responsible
- not part of an apparent pattern of abuse
- no clear criminal offence described in referral
- there is not a clear intent to harm or exploit the vulnerable person

### ACTION & OUTCOMES

- Service provider must recognise and record concern under their AP procedures
- Action taken by Service Provider to address 'presenting concerns' AND report outcomes to care manager/social worker
- May lead to minor alterations in the way service is provided to a vulnerable adult and/or alterations to the way staff or other resources are deployed in the delivery of health and social care
- No on-going risk to the vulnerable adult or other vulnerable people

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*Added to Guidance January 2006*
# Adult Protection Guidance

## RESPONSE
- **Level 2**
  - AP referral made to the agency with social services responsibilities
  - **Adult Protection Alert/Referral form must be completed**
  - Need to urgently assess or review the needs of the vulnerable adult within the context of the presenting concern(s)
  - Consult with police where a crime may have been committed. Refer if appropriate
  - If criminal offence, consider if level 3 response may be more appropriate

## PRESENTING INFORMATION
- The physical, psychological or emotional well-being of the vulnerable adult may be being adversely affected
- The concerns reflect difficulties and tension in the way health and/or social care services are provided to the vulnerable adult (e.g. Some perceived inadequacy in the services being provided)
- The concerns reflect difficulties and tensions within the network of informal support provided to the vulnerable adult (e.g. some perceived difficulties between the vulnerable adult and family/friends)
- Concerns have occurred in the past, but at lengthy and infrequent intervals

## ACTION & OUTCOMES
- The 'needs' of the vulnerable adult and if appropriate a vulnerable perpetrator are formally assessed or reviewed by a care manager/social worker/health care professional
- Determine if abuse occurred
- **If abuse confirmed or there was insufficient information for a determination to be made a post abuse care plan may include**
  - Possible adjustments to the way health and social care services are provided to the vulnerable adult or vulnerable perpetrator, to ameliorate 'presenting concerns'
  - Support may be provided to enable the vulnerable adult to explore and negotiate relationships with 'significant others' in their support network e.g. Family group conferencing
  - Carers assessment and support where indicated
  - Current and future risks of harm or exploitation are significantly reduced or eradicated by changes to a 'Health and Social care plan'

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*Added to Guidance January 2006*
<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>PRESENTING INFORMATION</th>
<th>ACTION &amp; OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| AP concern referred | • The physical, psychological or emotional well-being of the adult has been adversely affected by the alleged incident(s)  
• Criminal offence(s) may have been committed  
• There is a possible breach of regulations under the Care Standards Act (2000)  
• Possible breach of Professional Codes of Conduct  
• There is an actual or potential risk of harm or exploitation to other vulnerable people  
• There appears to be a deliberate intent to exploit or harm a vulnerable adult  
• There is a significant breach in an implied or actual 'duty of care' between the vulnerable adult and the alleged perpetrator.  
• There are clear inequalities of power and/or authority between the vulnerable adult and the person alleged responsible  
The concerns form part of a pattern of abuse either, against a particular individual, by a particular individual or by a health or social care service | • Multi agency planning discussion/meeting held to agree an 'Investigation Plan'  
• Investigation Plan implemented with further AP review discussions/meetings, if appropriate  
• Evaluation of investigation activity and evidence obtained  
• Report to be completed by investigating officer(s) to enable the case conference to determine the status of the allegations  
• Case conference to agree a 'Protection Plan' that prevents or reduces risk of further abuse  
• Agree Protection Plan  
• Agree review time scales for protection plan and allocate to named people  
• Agree circumstances where re-evaluation of the situation will be required |
| Adult Protection Alert/Referral form must be completed | Multi agency adult protection assessment/investigation undertaken  
Consult with police to determine if a criminal offence may have been committed. Make a formal referral if appropriate |                  |

Added to Guidance January 2006
<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>PRESENTING INFORMATION</th>
<th>ACTION &amp; OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 4</td>
<td>Complex adult protection investigations / assessments undertaken with multiple service users / victims&lt;br&gt;Adult Protection Alert/Referral form to be completed for all clients assessed /reviewed in relation to the alleged abuse&lt;br&gt;Consult with police, if crime possible refer issues to police and ensure that regulators are informed of concerns&lt;br&gt;Investigation of initial concerns for one service user identifies serious concerns for others&lt;br&gt;Institutional abuse&lt;br&gt;Number of vulnerable adults adversely affected&lt;br&gt;Criminal offences may have been committed&lt;br&gt;Possible multiple breach of Care Standards Act&lt;br&gt;Notify senior managers&lt;br&gt;Allocate resources to undertake, and co-ordinate investigation/assessment&lt;br&gt;Planning/strategy meeting held to agree an 'Investigation/assessment Plan'&lt;br&gt;Investigation / assessment plan implemented with further review meetings, if appropriate&lt;br&gt;Evaluation of Investigation /assessment activity and evidence obtained&lt;br&gt;Report completed by investigator(s)&lt;br&gt;Determine if abuse has taken place&lt;br&gt;Case conference to agree a 'Protection Plan' that prevents or reduces risk of further abuse&lt;br&gt;Agree Protection Plan&lt;br&gt;Agree review time scales for protection plan and allocate to named people&lt;br&gt;Agree circumstances where re-evaluation of the situation will be required&lt;br&gt;Establishment case conference/review meeting&lt;br&gt;Agree action plan for the service&lt;br&gt;Monitoring and review of action plan for service provider</td>
<td></td>
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</tbody>
</table>
**Adult Protection Framework**

- Adult Protection Reported to the Social Services Agency
- Decision that it appears to be an AP case
- Adult Protection Alert/Referral Form commenced
- **Consider initial risk level** (take action if necessary)
- Carry out initial enquiries, evaluate information and consider response

**Possible responses:**
- **Formal adult protection process followed**
- Carrying out a social care assessment for victim/carer
- Referral to more appropriate agency-GP, health
- Poor practice / quality refer to CQC/consider QIC framework
- Abuse discounted

**Abuse or harm - is it a possible crime?**
Therefore consult police - make formal referral if appropriate

- Record and notify referrer and agencies of the agreed response, if appropriate at this time

- Complete formal initial planning process (strategy decision) following consultation
- **Agree AP level of response (1 – 4)**
- **Review risk level**
- Record and agree a protection plan

- **Consider need for formal planning/strategy meeting**
- **Reconsider risk level**
- Decide who will take the lead in the investigation
- Record and agree a protection plan

**Level 1 Investigation**
The service provider must report back the outcome of their assessment /investigation.

**Level 2 Investigation**
Need to urgently assess or review the needs of the vulnerable adult within the context of the presenting concern(s)

**Level 3 / 4 Investigation**
Complex adult protection investigations / assessments undertaken with multiple service/victims

At **review planning/strategy meeting:**
- **formal review of findings from**

At **case conference:**
- Decision re outcome of investigation/assessment
- Agree post support plan
- Agree monitoring plan
- Close case
- Inform relevant people

**Timescales**
- **Within 24 hours**
- **Within 2 working days**
- **Within 5 working days following**

**Amended July 2011**
NHS Counter Fraud Service Role

Arrangements to Counter Fraud and Corruption were initiated in September 1998 and have been embodied in the Secretary of State directions as part of the National Health Service Act 1977. This initiated the creation of the Counter Fraud and Security Management Service (CFSMS). The NHS Counter Fraud Service has a remit of tackling all losses to fraud and corruption in every area of NHS spending.

Every NHS Health body in England and Wales had a designated Local Counter Fraud Specialist (LCFS) who is responsible for tackling fraud at a local level.

South Coast Audit is a not-for-profit consortium that provides a Local Counter Fraud Service to all NHS Trusts in Kent and Medway under the authority of the NHS Counter Fraud Service on behalf of the Secretary of State for Health.

Every Local Counter Fraud Specialist who is involved in the detection, investigation, or prosecution of fraud and corruption within the NHS has undertaken training that is comparable with Police training. A Memorandum of Understanding exists between the NHS Counter Fraud Service and the Association of Chief Police Officer and establishes guidelines to:

- Facilitate effective lines of communication by promoting clear understanding of NHS Counter Fraud Service and Police responsibilities, working procedures, and respective legal constraints.
- Assist police and NHS Counter Fraud Specialists to co-operate at an operational level.
- Facilitate effective investigation and exchange of information with the objective of detecting all forms of serious crime as well as fraud involving the NHS.

Activities that may be accompanied by criminal offences, which can be addressed by referral to the NHS Counter Fraud Service will more commonly include:

- Suspicions of theft from a vulnerable adult that involve a NHS member of staff. This may include theft of property or misuse of patient’s money or property.

The NHS Counter Fraud Service will consider a range of sanctions including, criminal, disciplinary and civil proceedings. Criminal Prosecutions can be undertaken using the Office of Solicitors for Department of Health or the Crown Prosecution Service.

The designated Local Counter Fraud Specialist will ensure that the investigation and reporting procedures defined within this document are complied with.

Key contacts:

Steffan Wilkinson
Head of Local Counter Fraud Service
Tel: 01622 713035
Mobile: 07799263978
Email: steffan.wilkinson@scaudit.org

Andrew Ede
LCFS for Kent & Medway NHS & Social Care Partnership Trust
Tel: 01303 297044 / 07979645948
Email: andrew.ede@scaudit.org

Peter Tucker
LCFS for Kent Community Health NHS Trust
Tel: 01303 297044 / 07799263908
Email: peter.tucker@scaudit.org

Updated July 2013
Prevent is the strand of the counter-terrorism work stream that aims to stop people becoming terrorists or supporting terrorism.

The new Prevent strategy is based on the conclusions of the Prevent Review published June 2011.

**Challenging extremist ideas**

Preventing terrorism will mean challenging extremist ideas that are conducive to terrorism or are shared by terrorist groups.

**Prevent objectives**

The objectives for Prevent will be:

- respond to the ideological challenge of terrorism and the threat we face from those who promote it
- prevent vulnerable people from being drawn into terrorism and ensure that they are given appropriate advice and support
- Work with a wide range of sectors (including education, criminal justice, faith, charities, the internet and health and social care) where there are risks of radicalisation which needs to be addressed

If you have concerns that a vulnerable adult may be a victim of radicalisation please contact Kent police.
Useful Addresses

For referrals to Kent Adult Social Services (updated July 2013)
If you have a safeguarding adults concern phone Kent contact centre number 03000 41 11 11 and you will be transferred to the Central Duty Team for a consultation or to make a safeguarding referral.
You can Fax through the AP1 to CDT using this fax number 03000 412345 — or for out of hours 01233 646596 this will be passed to the correct team within Social Services.

For referrals to Medway Council Adult Social Care (Updated January 2010)
Phone 01634 334466 a referral will be taken. You may also fax through your referral on 01634 334504. You may e-mail your referral on access&info@medway.gov.uk

---

Kent
Kent County Council
Headquarters
General Enquiries
County Hall
Maidstone
Kent ME14 1XQ
Tel: 03000 41 61 61
Fax: 01622 696492
Out of hours: 03000 41 91 91

24 hour contact centre
03000 41 41 41
03000 333 5540

East Kent Area Office
Thanet
St Peters House
Dane Valley Road
St Peters
Broadstairs, Kent CT10 3JJ
Tel: 01843 860000
Fax: 01843 864874
Minicom: 01843 860000

West Kent Area Office
Brenchley House
123-135 Week Street
Maidstone
ME14 1RF
Tel: 03000 41 61 61
Out of hours: 03000 41 91 91
24 hour contact centre
03000 41 41 41

Kent Police
Ask for the Local Combined Safeguarding Team
Countywide contact number: 101 or phone
01622 690690

Care Quality Commission
CQC South East, Citygate, Gallowgate; Newcastle upon Tyne, NE1 4PA
Email: enquiries.southeast@cqc.org.uk
Tel: 03000 616161
Fax: 03000 616171

---

Medway
Medway Council Headquarters
Level 4, Gun Wharf,
Dock Road, Chatham ME4 4TR
Tel: 01634 334466
Out of hours: 03000 41 91 91

Dover
Thistley House
Melbourne Avenue
Dover
CT16 2JH
Minicom: 01304 224300

East Kent Local Offices
Canterbury
Brook House, Reeves Way
John Wilson Business Park
Whitstable CT5 3SS
Tel: 01227 598500
Fax:

Maidstone
Bishops Terrace
Bishops Way
Maidstone ME14 1LA
Tel: 01622 691640
Fax: 01622 691135
No Minicom available

Swale
Avenue of Remembrance
Sittingbourne
Kent ME10 4DD
Tel: 01795 473333
Minicom: 01795 473333
Fax: 01795 420016

Sevenoaks
Swanley Local Office
The Willows
Hilda May Avenue
Swanley
Kent BR8 7BT
Tel: 01322 611000
Fax: 01322 611019

Ashford
Civic Centre
Tannery Lane
Ashford TN23 1PL
Tel: 03000 41 41 41
Fax: 01233 205700
Minicom: 01233 205777

---

Tonbridge
Croft House
East Street
Tonbridge
Kent TN9 1HP
Tel: 01732 362442
Fax: 01732 773371

Gravesend
Joynes House
New Road
Gravesend
Kent DA11 QAT
Tel: 01474 328664
Fax: 01474 320741
[minicom available]
## Kent & Medway NHS and Social Care Partnership Trust
### Integrated Mental Health Teams

<table>
<thead>
<tr>
<th>Team</th>
<th>Area</th>
<th>Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery Services</td>
<td>Swale, Canterbury and Coastal</td>
<td>Durham House, Herne Bay, Kent CT6 5SA</td>
<td>01227 594888</td>
</tr>
<tr>
<td>Access Services</td>
<td>Swale, Canterbury and Coastal</td>
<td>Laurel House, 41 Old Dover Road, Canterbury, Kent CT1 3HH</td>
<td>01227 597111</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>Dartford, Gravesham and Swanley</td>
<td>Arndale House, 18-20 Spital Street, Dartford, DA1 2DL</td>
<td>01322 622230</td>
</tr>
<tr>
<td>Access Services</td>
<td>Dartford, Gravesham &amp; Swanley</td>
<td>Arndale House, 18-20 Spital Street, Dartford, DA1 2DL</td>
<td>01322 622230</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>Maidstone</td>
<td>Kingswood Union Street, Maidstone ME14 1EY</td>
<td>01622 766900</td>
</tr>
<tr>
<td>Access Services</td>
<td>Maidstone</td>
<td>The Pagoda, Hermitage Lane, Maidstone ME16 9PD</td>
<td>01622 724200</td>
</tr>
<tr>
<td>Access Services</td>
<td>South West Kent</td>
<td>Highlands House, 10-12 Calverley Park Gardens, Tunbridge Wells TN1 2JN</td>
<td>01892 709211</td>
</tr>
<tr>
<td>Access Services</td>
<td>Thanet</td>
<td>The Beacon, Manston Road, Ramsgate CT12 6NT</td>
<td>01843 855200</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>Ashford</td>
<td>1 Elwick Road, Ashford TN23 1PD</td>
<td>01233 204150</td>
</tr>
<tr>
<td>Access Services</td>
<td>Ashford</td>
<td>1 Elwick Road, Ashford TN23 1PD</td>
<td>01233 204150</td>
</tr>
<tr>
<td>Access and Recovery Services</td>
<td>Medway</td>
<td>Kingsley House, 37-39 Balmoral Road, Gillingham Kent ME7 4PF</td>
<td>01634 331914</td>
</tr>
</tbody>
</table>

Amended July 2013
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Location</th>
<th>Address</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Services</td>
<td>East Kent</td>
<td>Coleman House, Brookfield Avenue, Dover CT16 2AH</td>
<td>01304 216666</td>
</tr>
<tr>
<td></td>
<td>West and Medway</td>
<td>Dr Meena McGill, Assistant Director: Rehabilitation and Placement Support, Pagoda CMHC, Hermitage Lane, Maidstone, Kent, ME16 9PD</td>
<td>01622 724221</td>
</tr>
<tr>
<td>Early Intervention (in Psychosis) Services</td>
<td>West and Medway</td>
<td>Medway Maritime Hospital, Windmill Road, Gillingham ME7 5NY</td>
<td>01634 830000</td>
</tr>
<tr>
<td>Early Intervention (in Psychosis) Services</td>
<td>Canterbury</td>
<td>Eastern and Coastal Offices, Littlebourne Road, Canterbury, Kent CT1 1AZ</td>
<td>01227 812390</td>
</tr>
</tbody>
</table>

**Trading Standards**

<table>
<thead>
<tr>
<th>Kent County Council</th>
<th>Kent County Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Kent Area Office</td>
<td>West Kent Area Office</td>
</tr>
<tr>
<td>KCC Highways Depot</td>
<td>8 Abbey Wood Road</td>
</tr>
<tr>
<td>Javelin Way</td>
<td>Kings Hill</td>
</tr>
<tr>
<td>Ashford</td>
<td>West Malling</td>
</tr>
<tr>
<td>Tel: 01233 898825</td>
<td>Tel: 01732 525291</td>
</tr>
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<table>
<thead>
<tr>
<th>Medway Unitary Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trading Standards</td>
</tr>
<tr>
<td>Gun Wharf</td>
</tr>
<tr>
<td>Chatham</td>
</tr>
<tr>
<td>Tel: 01634 333555</td>
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</table>

**Kent Sensory and Autism Services and Interpreting Team**

<table>
<thead>
<tr>
<th>Headquarters</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent County Council</td>
<td>01622 694975</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>East Kent Deaf Services</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent County Council</td>
<td>01304 224413</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>West Kent</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent County Council</td>
<td>01732 525393</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hi Kent Maidstone</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent County Council</td>
<td>01622 691151</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hi Kent Canterbury</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent County Council</td>
<td>01227 760046</td>
</tr>
</tbody>
</table>

**Kent Deaf Blind Team**

<table>
<thead>
<tr>
<th>Tel:</th>
<th>Minicom:</th>
</tr>
</thead>
<tbody>
<tr>
<td>01233 898697</td>
<td>01233 652258</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medway Deaf Services:</th>
<th>Tel:</th>
<th>Fax:</th>
<th>Typetalk:</th>
<th>Mobile:</th>
<th>Email:</th>
<th>Write to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel: 01634 331727 (voice and text)</td>
<td>01634 331199</td>
<td>18001 01634 331727</td>
<td>07795 951465 or by</td>
<td>Royal Association for Deaf People- Interpreting Service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Autistic Spectrum Conditions Team | Tel: | |
|-----------------------------------|-----||
| 01233 898715                      |     |
Appendix 1
Kent Social Services AP1 Alert Form (1 August 2013)

Adult Protection Alert Form for Service Providers and Members of the Public. Please ensure this form is completed as fully as possible if adult abuse is witnessed or suspected.

This form is designed to be completed as a word document and includes drop down boxes to support completion. There are free text boxes throughout the form and these sections will grow to accommodate the information being added. An electronic name will be considered as a signature within this document.

If you are unable to complete the form electronically a hand written form will be accepted. (Details of where and how to send the AP1 are found at the end of this form). If you require assistance in completing this form, please see the guidance notes on the kent.gov website: Guidelines to report adult protection concerns to the Social Services Agencies in Kent and Medway

<table>
<thead>
<tr>
<th>FOR INDIVIDUAL ACUTE TRUST INFORMATION TO BE ADDED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AP1</strong> Stage 1 – Alert</td>
</tr>
<tr>
<td>i. Name and Role/Relationship of person completing this form (s)</td>
</tr>
<tr>
<td>i. Do you wish to remain anonymous (s)</td>
</tr>
<tr>
<td>i. Contact Address and Telephone Number (Fax and/or email)</td>
</tr>
<tr>
<td>ii. Name and role or relationship of person who reported the alleged incident (if different from person named above)</td>
</tr>
<tr>
<td>ii. Do they wish to remain anonymous</td>
</tr>
<tr>
<td>ii. Contact Address and Telephone Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KCC OFFICE USE ONLY- DATE AP1 RECEIVED (Date of Alert) (s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method of contact: (s)</td>
</tr>
</tbody>
</table>
### Client's Details

<table>
<thead>
<tr>
<th><strong>Date(s) &amp; Time(s) of Incident(s) if known:</strong> (s)</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Client's Details</strong></th>
<th><strong>LA Client ID / Hospital ID / Rio Number/ NHS Number</strong> *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of client:</strong> (s)</td>
<td><strong>Title:</strong></td>
</tr>
<tr>
<td><strong>Client's Normal Address:</strong> (s)</td>
<td><strong>Address of where the alleged incident of abuse occurred:</strong></td>
</tr>
<tr>
<td><strong>Postcode:</strong> (s)</td>
<td><strong>Location, where did alleged abuse take place?</strong> <em>(s)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Is this a registered care home?</strong></th>
<th><strong>Communication needs</strong></th>
<th><strong>Is Support Required?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tel No. 1:</strong></td>
<td><strong>Speech:</strong> (s)</td>
<td></td>
</tr>
<tr>
<td><strong>Tel No 2:</strong></td>
<td><strong>Hearing:</strong> (s)</td>
<td></td>
</tr>
<tr>
<td><strong>Email:</strong></td>
<td><strong>Visual:</strong> (s)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Date of Birth:</strong> (s)</th>
<th><strong>Explanation of Communication Needs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of Death:</strong> (s)</td>
<td><strong>Interpreter:</strong> (s)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Gender:</strong> (s)</th>
<th><strong>First Language:</strong> (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status:</strong> (s)</td>
<td><strong>Details of Interpreter required</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Ethnicity:</strong> (s)</th>
<th><strong>Contact details of Advocate</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Orientation:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Religion:</strong> (s)</td>
<td><strong>Contact details of significant other</strong> <em>(s)</em></td>
</tr>
</tbody>
</table>

| **Next of Kin or significant other, address and telephone number:** (s) | **Contact details of nearest relative under MH Act** |

---

**100 Green**

---

**Adult Protection Guidance**
<table>
<thead>
<tr>
<th>Relationship to client (s)</th>
<th>General Practice address and telephone number General Practitioner (if known) (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the client aware that this concern is being reported to Social Service Agency*? (s)</td>
<td>If not, reason why?</td>
</tr>
<tr>
<td>Has the client given their consent to this information being shared with social services and / or other agencies*? (More details can be added in text box)</td>
<td>If no, reason why?</td>
</tr>
</tbody>
</table>

**Information will be shared with other agencies where issues of capacity to give consent are unclear and/or where the safety of other vulnerable people may be at risk or where a crime is suspected.**

To your knowledge has this client been the subject of previous adult protection alerts? (s)

**For Social Services** to explain if person has been subject to previous adult protection alert?

To your knowledge has this setting been the subject of previous adult protection reports?

**Key Professionals if known**?

<table>
<thead>
<tr>
<th>Social Services Case Manager</th>
<th>Contact Address</th>
<th>Telephone, Fax and Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Nurse/CPN/Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other significant professional/s</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is the vulnerable adult a carer?

Is the person under a Deprivation of Liberty Safeguards Authorisation? If so please give brief details

To the best of your knowledge Primary Category of client* (s)

(If you are completing by hand please describe whether physical, sensory, learning disability or mental health difficulties experienced)

Secondary Category of client if relevant:
Details of Allegation - what happened*? (Include information about any witnesses and their contact details. What has triggered the alert now?
Where possible provide details of the vulnerability of the subject of the alert. These may include communication issues, understanding, first language and any essential medical information. (Complete body map if appropriate.)


At this stage, do you have a view of the individual’s mental capacity regarding this adult protection alert and related concerns? Is there a known mental disorder?

Please give details:
**Type of alleged abuse** Identify all that are relevant (s)
Please tick the Domestic Abuse or HATE Crime beside any type of abuse that is also related to these

<table>
<thead>
<tr>
<th>Main category of abuse</th>
<th>Was the alleged abuse between partners?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>□</td>
</tr>
<tr>
<td>Financial</td>
<td>□</td>
</tr>
<tr>
<td>Emotiona / Psychological</td>
<td>□</td>
</tr>
<tr>
<td>Neglect</td>
<td>□</td>
</tr>
</tbody>
</table>

**Injuries Reported**

Please describe injury* - When recording an injury you need to try and include the following information:
- Exact site of injury; size of injury (cm or inches); approx shape of injury; colour of injury; is injury clean?
- Is the skin broken? Is there any swelling?
- Are there any scabs / blistering / bleeding present?
- Is mobility restricted; does the site feel hot? Does the client feel pain?:

Please also consider and record psychological impact on Client (if known):

| Is there a body map to be made available? please attach and send with AP 1. |
| Are there any photographic records of these injuries? Please attach |
| Has client been medically examined? |
| If yes – who by and when? |
| Is there a need to preserve any potential Forensic Evidence? |
If yes are you aware of – or have you been advised of what to do regarding forensic or other evidence? – please advise

Do you consider anyone else to be at risk e.g. other vulnerable adults or children

**Information about the main alleged perpetrator / organisation** *(Please provide, as much information as possible to enable the police to carry out necessary checks. If the identity of the alleged perpetrator(s) is not available do not delay sending the referral to the police if from your consultations a crime has or may have been committed.)*

*If an organisation is alleged to be responsible only limited parts of this section can be completed*

<table>
<thead>
<tr>
<th>Multiple Perpetrators</th>
<th>Next perpetrator – if yes please copy this page and attach to AP1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full name of a person or name of the organisation alleged to be responsible for the abuse. If unknown then state UNKNOWN (S)</td>
<td></td>
</tr>
<tr>
<td>Relationship of primary alleged perpetrator:* (s)</td>
<td></td>
</tr>
<tr>
<td>AKA / Alternative name:</td>
<td>Gender</td>
</tr>
<tr>
<td>DOB:</td>
<td>Age / Estimated age:</td>
</tr>
<tr>
<td>Home Address/Post Code/Telephone No:</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Occupation: (If Applicable)</td>
<td></td>
</tr>
<tr>
<td>Is the alleged perpetrator aware of the referral? (s)</td>
<td></td>
</tr>
<tr>
<td>Does the alleged perpetrator pose a possible risk to children? If yes, give details</td>
<td></td>
</tr>
<tr>
<td>Does the alleged perpetrator pose a possible risk to other vulnerable adults? (s) If yes, give details</td>
<td></td>
</tr>
<tr>
<td>Is the alleged perpetrator a vulnerable adult themselves? (s)</td>
<td></td>
</tr>
<tr>
<td>If yes, Vulnerability of Alleged Perpetrator if known: Include communication / understanding / capacity &amp; first language, Physical Disability, Learning Disability, any Mental Health problems &amp; any relevant medical information.</td>
<td></td>
</tr>
</tbody>
</table>

**Please record if a mental capacity assessment is required in relation to the alleged**
Does the alleged perpetrator care for others? (s)

Do they live with the vulnerable adult?

Has the alleged perpetrator been mentioned in previous referral(s) as an alleged perpetrator?

Details of any professional helper/s (e.g. Case Manager / Social Worker/CPN/Comm LD Nurses) involved in the care of the alleged perpetrator (if applicable name / role / telephone number):

Have you taken any immediate action? If so what?
Please attach relevant risk assessment or other documents/reports if available

Have you informed any other person/agencies of this alleged incident? Please give details. (Police, CQC, Health, Next of Kin)

<table>
<thead>
<tr>
<th>Name and/or role of person informed</th>
<th>Brief summary of contact – e.g. faxed, phoned, emailed etc and date sent.</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Name of person completing this alert form*:

Signature If completed by hand

Date*

If the Vulnerable Adult has an open referral with a Case Management Team please send this form directly to them. If you wish to check if the Vulnerable Adult is open, or require contact details for the Case Management Team please call 03000 41 11 11.

For all other cases please send to the Central Referral Unit;

CentralDutyTeam@kent.gcsx.gov.uk (Secure e-mail*)
central.duty@kent.gov.uk (Standard e-mail)
Secure e-mail is only secure when sending from one of the following e-mail addresses; @nhs.net @pnn.police.uk @gcsx.gov.uk @gsi.gov.uk

If you are sending information via a non secure e-mail please password protect the document and e-mail the password separately – do not include it in the body of the e-mail.

If you do not have an e-mail facility please fax the completed form to 03000 412345 (Safe haven Fax)

If your concerns require urgent attention outside of normal office hours (8:30am-5:00pm Monday-Friday, excluding bank holidays) and cannot wait until the next working day please fax to the Out of Hours Team on 03000 417345 (Safe haven fax)

If you wish to consult with Kent Social Services to discuss your concerns please call:

Normal working hours: 03000 41 11 11
Out of Hours: 03000 41 91 91
## Medway Council Adult Protection Alert Form

**Form AP1**

Service providers should ensure this form is completed if adult abuse is witnessed or suspected. If a criminal offence is witnessed or reported the police should be contacted as a matter of urgency. **Revised February 2013**

### Date Completed: | Date incident reported to person completing form:
--- | ---

<table>
<thead>
<tr>
<th>Name of person completing this form</th>
<th>Role and Profession</th>
<th>Contact address</th>
<th>Telephone, Fax and E-mail</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of person who reported the alleged incident</th>
<th>Role, Profession and Relationship</th>
<th>Contact address</th>
<th>Telephone, Fax and E-mail</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of alleged victim</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Marital Status</th>
<th>Ethnicity</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Current address</th>
<th>Telephone number</th>
<th>SS ID and/or NHS number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Next of Kin</th>
<th>Contact Address</th>
<th>Telephone, Fax and E-mail</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>GP</th>
<th>Practice Contact Address</th>
<th>Telephone, Fax and E-mail</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Key Professionals if known</th>
<th>Contact Address</th>
<th>Telephone, Fax and E-mail</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Care Manager / District Nurse / CPN</th>
<th>(if other please state)</th>
<th></th>
</tr>
</thead>
</table>
Does the alleged victim have any problems with sight, speech, hearing, language, or mental capacity if known? Please record if the alleged victim requires an interpreter, support with communication or an independent advocate.

<table>
<thead>
<tr>
<th>Is the alleged victim aware that you are contacting another agency?</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the alleged victim given permission to share information?</td>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
</tr>
<tr>
<td>Is the alleged victim purchasing services privately?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Date of Alleged Incident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time of Incident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of Alleged Incident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(please record any details known)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Type of alleged abuse** (please tick all that you consider to be relevant):

- [ ] Physical
- [ ] Psychological
- [X] Sexual
- [ ] Financial
- [ ] Neglect
- [ ] Discriminatory

- [ ] Do you believe that any of the allegations are domestic abuse? Yes | No

**Details of allegation:**

---

108 Green
What happened? Who was involved? Where and when did the alleged abuse take place?

<table>
<thead>
<tr>
<th>Name(s) of alleged perpetrator(s)</th>
<th>Date(s) of Birth</th>
<th>Gender</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Own home address(es)</th>
<th>Telephone number(s)</th>
<th>Role / Relationship to Service User</th>
</tr>
</thead>
<tbody>
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</table>

Have you taken any immediate action? If so what?  
Have you informed any other person/agencies of this alleged incident? Please give details (Police, CQC, Health).

Do you consider anyone else to be at risk? E.g. other vulnerable adults and/or children.  
Yes | No | Unsure

You may be asked to forward any statements, incident/accident reports, body map(s) if relevant:
Please tick the box if you require extra space and intend to send any additional pages (hard copy only).

Please complete details below when sending a hard copy and keep an original for your own records.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signed</th>
<th>Date</th>
</tr>
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<tbody>
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