Surrey County Council Adult Social Care

Safeguarding Good Practice Guidance

Part 1: Putting the Surrey Safeguarding Adults Enquiry Method in to practice

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SURREY

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Content includes material adapted, with thanks, from

- Sussex Safeguarding Adults Policy and Procedure
- William Hare, "Helping Open-Mindedness to Flourish" *Journal of Thought* 47(2001)
- "How to make organisations more innovative, open minded and critical in their thinking and judgment" WARC Best Practice September 2017
- "Safeguarding adults at risk: Financial abuse toolkit" Kent County Council
- Solihull Local Practice Guidance 21 "Financial Abuse and Safeguarding Adults"
- "Financial Abuse and Scams" (ADASS / LGA / PSW network / National Trading Standards scams team)
- Hampshire Safeguarding Adults Board Policy and Procedure

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Good Practice in Adult Safeguarding Work

Part 1: Putting the Surrey Safeguarding Adults Enquiry Method in to practice

1 Open minded adult safeguarding work

We approach our adult safeguarding work with the aim of being open minded, by which we mean

- being genuinely concerned to avoid bias, wishful thinking, and other factors, that threaten to compromise a serious examination of the evidence
- being ready to view one's conclusions, no matter how strongly supported, as potentially revisable in the light of further evidence given the fallible nature of knowledge

At the root of this is a recognition that if we are to do what we should to protect and support adults with care and support needs who are at risk of abuse or neglect requires us to have a genuine desire to know and understand the circumstances around that person and what they have experienced.

The expectation on our staff is that in carrying out adult safeguarding work they are prepared to do their best to establish whether or not there is are grounds for the adult safeguarding concern, and they will do this in an open-minded way which involves

- Taking account of any relevant evidence;
- Making the best judgements and decisions that we can using that evidence, applying relevant and up-to-date knowledge as needed, and doing so in ways that minimise the impact of bias and errors in decision making;
- Accepting when an unwelcome conclusion follows from that evidence; and
- Allowing that when new evidence requires it, we will change our position

1.1 Biases that can prevent open-minded safeguarding adults work

1.1.1 Confirmation bias

This is when we seek or interpret evidence in ways that support our pre-existing beliefs or hypotheses. Confirmation bias is extremely common in all sorts of decision-making and is the cause of many faulty beliefs and behaviours.

There are two main ways in which confirmation bias can affect our thinking:

- **Biased selection of evidence**: We notice and select evidence that supports our hypothesis. And typically, evidence that supports our belief is more salient and is better remembered than contradicting evidence, and we give more weight to it.
- **Biased interpretation of evidence**: Even when evidence is selected impartially, we are prone to interpreting evidence to favour our own position. People with opposing views can even draw opposite conclusions using the same evidence. In the words of Warren Buffet: "What the human being is best at doing is interpreting all new information so that their prior conclusions remain intact."

1.1.2 Optimism bias

This is the tendency to overestimate our likelihood of experiencing good events in our lives, and underestimate the likelihood of suffering from negative events in our lives.

1.1.3 Groupthink and 'Happy talk'

We are highly social beings which often means we prioritise conformity and fitting in with a group, even if it is to the detriment of wider outcomes such as business success, creativity and innovation and honesty.

We tend to like those who are the same as us, who have the same views and think in the same way. So we might well fear that putting forward contradictory views could threaten how accepted we'll be by our peers. When people are feeling anxious and less confident they may also not want to look foolish by saying what might be ill-founded. This can mean that decisions can often be poor due to the effects of groupthink: there is no evidence that groups eliminate the individual cognitive biases we all suffer from to some degree and they may even amplify them.

A related concept is 'Happy talk', defined by Cass Sunstein. This is when group members say that there is nothing to worry about, all is going well and likely to go even better. These members silence themselves, not reporting what they know to be potentially negative issues (despite being valuable information), because they want to please their peers, or don't want to cause anxiety or disrupt the status quo with contrary suggestions.

Sunstein finds that 'happy talk' is a pervasive source of group failures because 'no boats are rocked' and it breeds a culture of overconfidence and pretence, masking real problems.

1.1.4 Anchoring

This is our tendency to rely too heavily, or "anchor," on one trait or piece of information, often in the immediate context when making decisions. People can be influenced by anchoring effects in all sorts of contexts, from the price we negotiate on a deal, to the safety thresholds we set for products and services, to the fines or rewards we impose, or who we hire and promote.

1.1.5 Availability bias

This happens because what is most vivid or easy to bring to mind feels most likely to happen. We are typically bad at estimating probabilities, tending to make decisions based not on statistics and historical fact which can provide a good idea of how likely it is an event may occur, but rather on memorable, anecdotal evidence that we've seen or experienced with our own eyes, or which we've heard about through the media or from our peers.

1.2 Five simple strategies to reduce bias in decision-making

Here are five simple strategies to improve individual decision-making:

1.2.1 Consider the opposite

Whilst some cognitive strategies are highly specific to a particular kind of bias, this strategy has been shown to reduce the effects of several different biases, including overconfidence, anchoring effects, confirmation bias and hindsight bias.

The basic idea is to ask yourself the question: what are some reasons that my initial judgement might be wrong?

This has been shown to help us to look more broadly at the context and information available to us and focus our attention on contrary evidence for why our initial response may be flawed or why a new venture might fail.

1.2.2 Forecast twice

To help us make more accurate forecasts, make one forecast, then assume that was wrong and make a fresh guess, without anchoring to it. Then take an average of the two.

Research has shown that when people thought twice about a problem, they tended to consider it from a different perspective, or recalled different evidence or information which led them to reconsider. This can help to counter availability bias and other effects, by giving us time to recall and search for other relevant information.

Other research has identified that people make better judgements if they critique their first estimate and make a second. People who take a step back from their initial judgement and think it through from another perspective, make more accurate forecasts overall. If you can 'sleep on it' before you make your second guess, even better, since you'll likely return to the problem less fatigued, sharper and more able to recall and think through important factors. Just putting some distance between your first and second estimate – perhaps a few hours, or ideally days or weeks – has been shown to improve estimation.

1.2.3 Take an outsider's view

Imagine you're observing the decision you face from the outside, perhaps outside your team or organisation. What would someone on the outside advise or think was likely? Taking a different perspective can help to counter confirmation bias where our strong beliefs may distort the information we have collected for making the decision and how we have analysed it.

At a practical level, this could mean making a habit of reading from and talking to sources who are likely to have a different viewpoint.

1.2.4 Make a low, medium and high estimate rather than stating a range

Make a low, medium and high estimate for a forecast or outcome. Only stating a range can lead us to give a narrower range due to overconfidence, but we give wider estimates when we think about our low and high estimates separately. As a guide, these low and high estimates should be unlikely, but still possible. This approach works because it encourages us to think through a broader set of possibilities.

1.2.5 Build mechanisms for feedback

Finally, receiving feedback on our decision-making is crucial if we want to improve it. Without this, we may not realise when we've used a sub-optimal decision-making process, especially if feedback on our decision is delayed or if it's not clear what caused the eventual outcome.

1.3 Managing bias in our adult safeguarding work

The Surrey Safeguarding Adults Enquiry Method (SSAEM) is intended to help manage out biases from safeguarding adults enquiries. By using the Method the impact of biases in thinking will be reduced.

2 How to approach adult safeguarding work

Adult safeguarding concerns arise in an enormous variety of situations and each has its own complexities. It is not only impossible to be prescriptive about dealing with such a range, it will be counterproductive. The experience of safeguarding work with children and adults has shown that when procedures and processes become overly prescriptive, they get in the way of good practice.

Eileen Munro wrote about this in her final review of children's safeguarding. She wrote

> "Too much prescription reduces scope for professionals to respond appropriately to each individual case and … this reduces the quality of outcomes … A policy in a controlling system must have available a variety of responses that is at least as great as the variety of circumstances it seeks to control . In simple terms, a controller must be flexible enough to cope effectively with the full range of situations it will encounter. In the case of child protection this implies that, because the variety of needs is very high, a similarly wide scope in the nature of any interventions is required to identify in what areas help is necessary and what support services should be offered"
>
> (Munro final report, pages 137 – 138)

2.1 Form follows function

When deciding how a safeguarding enquiry is to be carried out, it is essential to keep in mind what it is that the safeguarding enquiry needs to achieve.

The first objective of an adult safeguarding enquiry is to establish the facts of what happened so that we can answer the questions

- Has the person experienced, or been at risk of, abuse or neglect?
- What needs to happen to help the person secure any changes they want
    - What needs to happen to help the person protect himself or herself?
    - What needs to happen to help the person secure justice or redress?
- If there has been abuse or neglect, or risk of these
    - What were the causes?
    - What needs to happen to apply any lessons learned?

An adult safeguarding enquiry might only take a few minutes, or it may take months. The issue of timing is a judgement to be made case-by-case. What is important, though, is to make sure that

- Drift is avoided,

- The process is being managed actively
- People are being kept informed about what is going on
- There are systems in place to pick up when any of these aren't happening and take action

2.2 Phases of the work as sets of questions

The phases of the work set out in the Surrey Safeguarding Adults Enquiry Method (SSAEM) should not be thought of as a set of tasks or bureaucratic divisions such as a sequence of meetings. The most useful way to think of them is as a series of sets of questions. Once enough of the questions in one phase have been answered, or it is clear they cannot be, then the process can move on.

2.2.1 Questions to address during the Plan

- Do we know what people want from this process and how they will be involved?
    - What outcomes are important to the person at risk? What support will they need? If we don't know, how do we find out?
    - Is there need for advocacy? Is there a need for an IMCA?
    - How will the person who may have caused harm be involved in the process? Do they have any needs we should take account of?
    - What outcomes are important to other people involved?
    - Are there any outcomes at odds with one another? What can be done to resolve this?

- What will be the breadth and depth of the enquiry?
    - What are the possible explanations for what may have happened?
    - What information would help choose between the different explanations?
    - What information do we have? What information are we missing and how can we get it?
    - Which other processes will contribute to the enquiry process? What resources will the partner organisations commit to the enquiry?

- What will the enquiry process look like?
    - Is there a need for one or more meetings, for people to contribute to planning the enquiry? Who needs to be there? Who will chair? Who will make the arrangements?
    - Does this enquiry relate to any other safeguarding enquires underway? How will these processes relate to one another?
    - Are there other processes underway already or which could be used that can contribute to the safeguarding enquiry?

- Are there other processes underway already or which could be used that the safeguarding enquiry can contribute to? Would they need particular things do be done
- Who will collate the information gathered? When and how will other people contributing to the enquiry supply them with the information needed?
- Who is managing the enquiry process? When will the person pulling the information together provide them with the collated information?
- Have we got the right people involved? Have they got the right support? What resources will be needed and who can commit them?
- Is there a risk of our decision-making being impaired by a sense of crisis? if so how do we improve this?
- Who will do what, in what order, and when?

- How will we manage risks
  - What risks are there, what protective factors are there, and what else can be done to mitigate risks?
  - What would increasing risk look like, and what should people do if that happens?

- What is the interim safeguarding plan?

2.2.2 Questions to address during the Do phase

- Is the process on track? If not, what do we need to do about it? Who needs to know
- Is the multi-agency working proceeding as it should? If not, how can any problems be resolved?
- Has the picture of risk changed? What do we need to do about it? Who needs to know?
- Does everyone know what is going on? What do we need to do to keep them informed?
- Does the strategy need to change?

- Is the information I have been given true? How do I know?
- Are there gaps, inconsistencies or contradictions in the information received? How will these be resolved?
- Is there a need for independent or expert analysis or judgement on any of the information received? Who will provide this and how?
- What are the views of the person who was at risk of abuse? What are the views of their friends and family?

- Has there been abuse or neglect, or risk of these?
    - What was the concern?
    - What has been established about whether this happened and, if so, why did it happen?

- What is the current picture of risk
    - Are there still risks to the person? What can be done to manage these?
    - Are there risks to other people? What can be done to manage these?

- Have the outcomes that the person at risk of abuse wanted been achieved? Is there anything else that can be done to achieve these?
- What will the safeguarding plan be?
- How will the safeguarding plan be implemented, monitored and reviewed?
- Is there a need to request consideration of a Safeguarding Adults Review?
- Should the findings of this enquiry trigger or inform other processes?
- Are there any lessons to be learned from how the safeguarding enquiry was carried out?

3 Safeguarding adults concerns and enquiries

3.1 Concerns and enquiries

Section 42 of the Care Act 2014 says we must ensure that there is an adult safeguarding adults if we have a reasonable belief that an adult in Surrey who has care and support needs

- is experiencing or is at risk of abuse or neglect; and
- as a result of their care & support needs, is unable to protect themselves against that abuse or neglect

A safeguarding adults concern is a concern brought to the attention of the Surrey County Council by anyone who believes that they or someone else might be in a situation which will meet the criteria for triggering the duty to have a safeguarding enquiry.

The possibility of abuse can come to light in various ways, for example:

- an active disclosure of abuse by the adult;
- a passive disclosure of abuse where someone's attention is drawn to the signs of abuse or neglect;
- an allegation of abuse by a third party;
- a complaint or concern raised by an adult or a third party who doesn't perceive that it is abuse or neglect.

The definition of a safeguarding concern is a broad one, which means it is a low threshold. The advantages of a low threshold are:

- It enables transparency around decision making in response to concerns;
- It gives a comprehensive picture of risks that come to the attention of that adult safeguarding board;
- It improves the likelihood of better judgments being made about those risks;
- It gives a means of identifying patterns of concerns;
- It gives an environment in which preventative working may be more likely;
- It helps to avoid "false negatives", that is to say it helps avoid the screening out of situations in which significant risk is not readily apparent in first contact. This is known to be a feature in much adult safeguarding work, and has been identified in some serious case reviews such as Stephen Hoskin, Margaret Panting, and Winterbourne View

The drawbacks of a low threshold are

- It may increase the demands on already stretched services;
- There is the potential of diversion from other issues
- It risks diverting resources to dealing with "false positives", those situations that appear at first to be very risky, which later turn out not to be. These are a challenge in all adult safeguarding work

To mitigate these drawbacks, two principles are of particular importance in safeguarding adults work:

- **Proportionality**: Matching the response to the nature of the concerns is essential. The response should not get bogged down in rigid processes that are out of kilter. Straightforward issues should have a straightforward response, which will enable a fuller response to those situations that need it
- **Partnership**: Communities, professionals and organisations need to work together to find ways of working together in response to concerns which ensures responsibilities for action are sitting in the best place, and which avoid overlap and duplication

3.2 Actions to take when a safeguarding adults concern is reported

The actions to take when a safeguarding adults concern is received are

- Check actions have been taken to address immediate safety needs, such as getting medical attention or contacting the Police. If necessary, take action to address safety needs.
- Make checks with person raising the concern, internal information sources and partner agencies to provide additional background information.
- Make contact with the adult referred to understand their views and wishes about the concern, unless doing so would place them or others at further risk of harm, or compromise a criminal investigation

The purpose of making checks and gathering more information at this stage is to

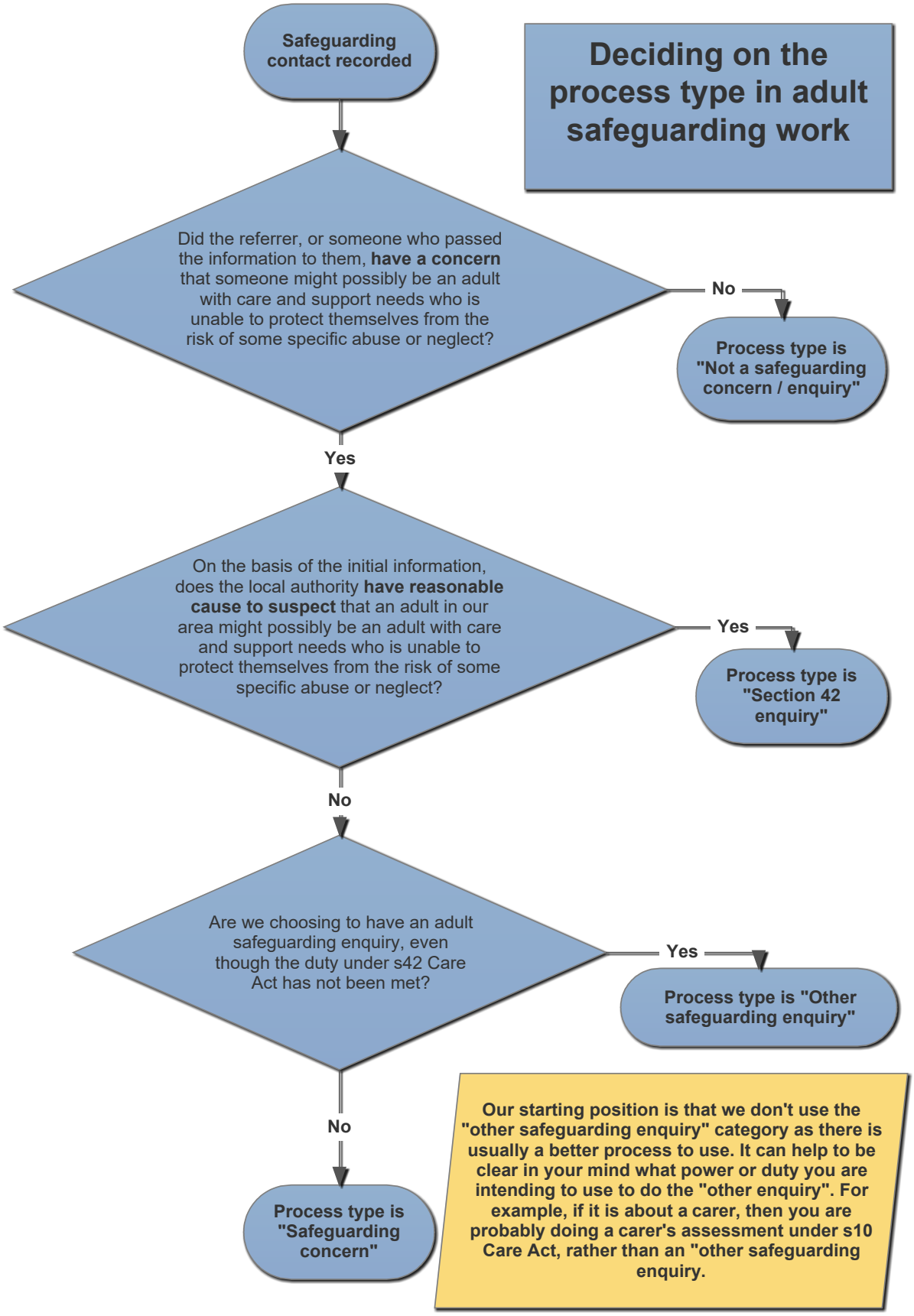
- assess/address any immediate safety & protection needs
- to gain the views of the adult, and
- to ascertain if the concern meets the criteria for a statutory enquiry under s42 of the Care Act, or if other action is required to respond to the concern

If the concern relates to a potential crime there should be early liaison with the police to agree next steps, and to avoid contamination of evidence.

Previous contacts and history should be checked for both the adult and the person thought to be the source of risk, including any information about possible risks to workers visiting.

3.2.1 The purpose of information gathering at this point

It is important to be clear what the purpose is of information gathering at this stage. It is to collect and/or clarify information needed to allow a decision to be taken whether the s42 enquiry criteria are met. In many instances, this decision can be made on the basis of what is already know, or with only a little more information needed


Deciding on the process type in adult safeguarding work
Safeguarding contact recorded
Did the referrer, or someone who passed the information to them, have a concern that someone might possibly be an adult with care and support needs who is unable to protect themselves from the risk of some specific abuse or neglect?
No
Process type is "Not a safeguarding concern / enquiry"
Yes
On the basis of the initial information, does the local authority have reasonable cause to suspect that an adult in our area might possibly be an adult with care and support needs who is unable to protect themselves from the risk of some specific abuse or neglect?
Yes
Process type is "Section 42 enquiry"
No
Are we choosing to have an adult safeguarding enquiry, even though the duty under s42 Care Act has not been met?
Yes
Process type is "Other safeguarding enquiry"
No
Process type is "Safeguarding concern"
Our starting position is that we don't use the "other safeguarding enquiry" category as there is usually a better process to use. It can help to be clear in your mind what power or duty you are intending to use to do the "other enquiry". For example, if it is about a carer, then you are probably doing a carer's assessment under s10 Care Act, rather than an "other safeguarding enquiry.

3.3 Making a decision whether there will be a safeguarding enquiry

Once all relevant information has been gathered, including the views of the adult in all circumstances where it is possible and safe to ask, the SAD should be in a position to make a decision about how the concern should be addressed and whether the criteria for statutory s42 duty of enquiry are met.

Where the criteria are met, the case will progress to a Safeguarding Adults Enquiry.

3.4 Timeliness of actions and decision making

Some adult safeguarding concerns will require an immediate response to safeguard the adult. As a target, an assessment of immediate risks and action needed, and a decision made about whether a safeguarding enquiry is required, should be taken by the SAM by the end of the next working day after we first received the adult safeguarding concern.

3.4.1 Doubts about meeting the s42 tests

Risk of delay in making a decision about whether an adult safeguarding enquiry is needed can arise because there is uncertainty over whether the tests in s42 of the Care Act. Experience has told us that the risks created by not making a timely decision outweigh the risks created by deciding to undertake an enquiry in circumstances where it turns out that sometimes the s42 tests weren't met.

If there are still doubts about whether the tests are met by the end of the working day after the concern was received, then the presumption should be made that they have been and the decision made to move on to an enquiry.

3.5 When a concern does not lead to an enquiry

The criteria in section 42 of the Care Act for a safeguarding adults enquiry might not be met, for example in circumstances where

- The adult is at risk of abuse or neglect but does not have care & support needs
- The adult has care & support needs, may have experienced abuse or neglect in the past, but is no longer experiencing or is at risk of abuse or neglect
- The adult has care & support needs, is at risk of abuse or neglect, but is able to protect themselves from abuse or neglect should they choose to.

An example of a situation falling in the third case would be where a person with a physical disability has been a victim of identity theft, but there is no reason to believe they were targeted because of their disability or that their disability prevents them from protecting themselves in the same way that any other citizen might.

Where the criteria for a safeguarding adults enquiry are not met, consideration should be given to what other action, or provision of advice and information might be required to respond to the concern. For example

- People can be supported to live safely through good quality assessment and support planning.
- People's right to live free from crime can be supported through Police interventions, and to recover from the experience of crime through victim support services.
- People's health & wellbeing, and experience of safe services, can be promoted through patient safety approaches in the NHS and good quality responses under Clinical Governance processes.

Where the criteria for statutory enquiry are not met, other types of action, or provision of advice/information, could be

- Referral for a needs assessment under s9 of the Care Act.
- Application for a Deprivation of Liberty Safeguards authorisation
- Referral for Mental Health Act assessment.
- Referral to other risk management processes, such as MARAC or MAPPA
- Referral or signposting to other agencies or support services, such as the Police, victim support, domestic abuse support services, counselling services, or a GP.
- Written information and advice on how to keep safe, or how to raise a concern in the future.
- Information about how to make a formal complaint, for example, about substandard care or treatment.
- Information sharing with regulatory agencies and commissioners to address service quality concerns.
- Service Provider to undertake appropriate internal responses, e.g. internal investigation, training, disciplinary process, audit & assurance activity.
- Concern is passed into other incident management processes, e.g. NHS Serious Incident process.
- Referral to the appropriate DASM in relation to concerns about people in a position of trust who may pose a risk of harm to adults.
- Referral for Safeguarding Adults Review (Care Act s44)

3.6 Dealing with historic allegations of abuse or where the adult is no longer at risk

Where the disclosure relates to abuse the person may have experienced when they were under 18 years old, it is a child protection matter and child protection procedures should be followed.

Section 42 (1) (b) of the Care Act says that one of the tests to determine whether there is a duty for there to be a safeguarding adults enquiry is that the person "is experiencing, or is at risk of, abuse or neglect".

In practice, some difficulties can arise because this is written in the present tense. For example

- A concern may arise that a person is at risk of abuse, and a decision is made to refer this to the local authority
- Perhaps through a combination of processes within the organisation where the concern has arisen, the time taken to pass the concern to the local authority, and for the concern to reach the appropriate decision maker in the local authority, the circumstances may have changed. For example, the person may have died in the interim. The person in the local authority making a decision whether there must be an adult safeguarding enquiry faces a dilemma.
    - Should they apply the test in s42 as per the circumstances on the day the concern arose, in which case the test is met
    - Should they apply the test in s42 as per the circumstances today, in which case the test is not met

The position agreed by Surrey Safeguarding Adults Board is

- Unless and until there is case law that clarifies this, there will be uncertainty on this matter and a need for sound professional judgement
- The starting point should be that if the tests in s42(1) were met at any point during the period from when the concern arose to when the decision is being made then the presumption should be that there will be an adult safeguarding enquiry
    - Factors that would strengthen this presumption might include there being risks to other adults with care and support needs, there being some public interest in the matter leading to an adult safeguarding enquiry, and an adult safeguarding enquiry being likely to promote public confidence in the services involved
    - Factors that may lead to a reversal of the presumption might include that there were no apparent risks to others, no questions to be addressed about the actions of any agencies involved, or if there was going to be another process that might provide sufficient scrutiny such as a Safeguarding Adults Review (and taking account that the aims of an Enquiry and Review are different)
- For the absence of doubt, the decision in question here is one that sits with the local authority under s42 of the Care Act. These are not matters that should lead to a decision not to refer an adult safeguarding concern to the local authority. Paragraph 14.199 of the Care and Support statutory guidance applies: “It is not for front line staff to second-guess the outcome of an enquiry in deciding whether or not to share their concerns.”

In cases where an adult has died or suffered serious abuse or neglect, and where there is concern that agencies should have worked more effectively to safeguard the adult, there is a statutory requirement for Surrey Safeguarding Adults Board to undertake a Safeguarding Adults Review under section 44 of the Care Act, and the SAD should consider referring this to Surrey Safeguarding Adults Board.

4 Root cause analysis in a safeguarding enquiry

4.1 What is root cause analysis?

Root Cause Analysis (RCA) is an investigative tool which can help to understand why abuse or neglect has occurred in service settings.

Once the basic facts of what happened have been established, using the RAC approach to guide the enquiry can help to understand the contributory factors and causal factors. This can help develop safeguarding plans that put in place corrective measures. By directing corrective measures at the root cause it is hoped the likelihood of the abuse or neglect reoccurring will be reduced.

4.2 Undertaking a root cause analysis

First, set out what has been established about the abuse or neglect

- Give a background history and description of the event
- Give the day, date and time of the incident or event, and when it was reported
- Identify what are the key issues to be looked at, for example
    - Why did person A take person B's money?
    - Why did the care worker not arrive to give the adult the care that had been commissioned?
    - Why is the adult experiencing the anti-social behaviour?
- Set out, in a few bullet points, what evidence has been gathered to inform the enquiry

4.3 The Root Cause Analysis questions

Then address the RCA questions. Each of them should be answered "Yes" or "No", and reasons for the answers should be given

4.3.1 Did existing systems or processes, or a deviation from current systems or processes, contribute to the incident/event?

- Did internal or external policies or procedures (or the lack of them) affect this incident?
- Are the relevant policies or procedures up to date, available at appropriate locations, widely known, realistic, understandable/useable, clear/unambiguous, available in appropriate languages and formats, adhered to/followed, have or need timescales and expected outcomes?
- Do staff agree with the policy or process, been consulted, do they have "buy-in"?

4.3.2 Did service-user factors contribute to the incident/event?

- Did medical conditions or care needs affect this incident? e.g. complexity of clinical or care need, general health, pre-existing or new illnesses or disabilities, poor sleep pattern, malnourishment/ dehydration.
- Did language or communication needs affect the incident?

- Social factors, e.g. culture/religious beliefs, lifestyle choices- alcohol/drugs/smoking/diet, living conditions (dilapidated/unsafe), support networks.
- Mental or psychological factors, e.g. motivation, stress- family pressures/financial pressures, emotional trauma, existing or new mental health needs.
- Interpersonal relationships – service-user to staff, service-user to service-user, family relations

4.3.3 Did staff behaviour contribute to the incident/event?

- Physical & mental health. e.g. fatigue, disability, stress, depression, impairment due to illness, drugs, alcohol etc
- Staff motivation e.g. boredom, low job satisfaction, overload, distraction, preoccupation
- Personality issues eg: low self-confidence or overconfidence, risk averse/risk taker, shy/timid or outspoken.
- Staff member domestic or lifestyle issues
- Beliefs, culture or religion of staff member
- Interpersonal relationships with service-users, colleagues, managers

4.3.4 Did communication factors contribute to the incident/event?

- Did poor or inadequate communication affect the incident?
- Verbal communication- were verbal commands/directions clear and unambiguous, made to the right person, use of language correct for the situation, was tone of voice and style of delivery appropriate & effective, were established communication channels used and were they effective
- Written communication – as above, plus were records easy to read, are records accessible and available in the right location when required, records complete, are records missing or been tampered with.
- Any non-verbal communication issues –aggressive or intimidating behaviour, body language- closed, open, relaxed, stern faced etc

4.3.5 Did staff training/skill contribute to the incident/event?

- Competence- did staff have adequate knowledge, skills, length & quality of experience, task familiarity? Had the relevant staff knowledge & skills been assessed/tested?
- The quality and content of local induction training or other relevant training
- Did staff had adequate supervision and/or mentoring?
- Had staff had refresher training to update themselves?
- Were the staff subject to regular appraisal?

4.3.6 Did staffing resources or work conditions contribute directly to the incident/event?

- Skill mix, use of agency/bank staff, workload / dependency assessment, staff turnover/retention
- Workload & hours of work- shift related fatigue, staff to service-user ratio, breaks during work hours, extraneous tasks, social relaxation, rest & recuperation
- Time pressure, delays caused by process design or failure of systems/processes

4.3.7 Did a malfunction or absence of equipment appear to contribute to the adverse incident/event?

- Whether the equipment was subject to an up to date maintenance programme, correctly stored, labelled, relevant instructions in place & legible, new or familiar to the user/s, fit for purpose
- Whether the equipment was familiar to those using it and if they were competent to use it
- Whether a safety mechanism failed

4.3.8 Did team, leadership or organisational factors affect this incident/event?

- Were the relevant roles within the staff team known, understood & followed, accountability & responsibility boundaries known and followed, code & expectations of conduct known & followed
- Is there effective leadership & management- can the leader lead, is the leader respected
- Management & Team culture, morale, openness, reactions to conflict, reaction to newcomers
- Organisational issues – hierarchical/inflexible structures- not conducive to information or problem sharing/discussion, support networks for staff, lack of safety culture & focus on safety,
- Organisational priorities – safety driven, financially focussed, performance driven, risk averse

4.3.9 Did controllable environment factors directly affect the outcome?

- Design of physical environment- cramped, temperature, panic buttons, lighting, noise levels
- Environment issues- e.g. water on the floor, a door that was locked preventing entry/exit,
- Has the relevant environment/task been subject to a risk assessment? If answering yes, provide a copy. If answering no, state why

4.3.10 Are there any uncontrollable external factors truly beyond the organisation's control?

- Examples might include an internal or external agency staff strike, adverse weather conditions, national pandemic, a failure of telephone systems, etc

4.3.11 Are there any other factors that have directly influenced this outcome?

4.4 Addressing the identified causes

For each area where the answer was “Yes”, action(s) should be identified to prevent or minimise the chances of reoccurrence. Controls should be considered following this hierarchy

4.4.1 Eliminate

Can you eliminate the problem? e.g. stop using an agency that sends unreliable, poorly trained locum staff

4.4.2 Substitute

Can you substitute the problem with something less harmful / risky? E.g. using a different moving & handling technique.

4.4.3 Isolate/distance

Can you isolate or distance the problem from people?

4.4.4 Safe Systems of Work

Can you create, or improve upon, safe working procedures to minimise or eliminate the problem?

4.4.5 Training/knowledge/information/Supervision

Can you provide additional training or supervision to staff to minimise or eliminate the problem?

4.4.6 Personal Protective equipment

Can you provide protective equipment to staff or patients to minimise harm to them. E.g. sharps boxes to prevent sharps injuries, pressure mats or sensors, etc

5 Developing a safeguarding plan

5.1 What a Safeguarding Plan should include

Safeguarding plans can cover a wide range of interventions and should be as innovative as is helpful for the adult. Care Act statutory guidance states that in relation to the adult, safeguarding plans should set out:

- what steps are to be taken to assure their safety in future;
- the provision of any support, treatment or therapy including on-going advocacy;
- any modifications needed in the way services are provided;
- how best to support the adult through any action they take to seek justice or redress;
- any on-going risk management strategy as appropriate; and,
- any action to be taken in relation to the person or organisation that has caused the concern.

The Safeguarding Plan should include, relevant to the individual situation:

- Positive actions to promote the safety and wellbeing of an adult, and for resolution & recovery from the experience of abuse or neglect; and,
- Positive actions to prevent further abuse or neglect by a person or an organisation.

The Safeguarding Plan should also include consideration of what triggers or circumstances would indicate increasing levels of risk of abuse or neglect for individual/s, and how this should be dealt with, such as who to contact or how to escalate concerns.

5.2 The ten principles approach

A common model in crime prevention is the “10 principles” approach. This framework can be usefully adapted to help generate ideas and options when developing safeguarding plans.

5.2.1 Principle 1: Target hardening

Take measures to make it physically more difficult for the abuse or neglect to take place, such as

- fitting better or stronger locks
- provision of care and support services to promote safety and wellbeing
- Activities, personal development and awareness raising that increase a person’s capacity to protect themselves

5.2.2 Principle 2: Target removal

The permanent or temporary removal of vulnerable persons or property, such as having secure storage for money or valuables

5.2.3 Principle 3: Removing the means to commit abuse or neglect

Making sure that material capable of being used to help someone commit abuse or neglect is not accessible, such as not giving others the person’s bank cards and PIN numbers

5.2.4 Principle 4: Reduce the payoff

Reduce the gain if abuse or neglect should take place, such as

- property marking to make items identifiable
- An application to Court of Protection to obtain Deputyship, enabling finances to be secured

5.2.5 Principle 5: Access control

Restricting access to a person or to the whole or part of buildings or sites, such as

- entry phones,
- using ID cards
- having security staff
- preventing a known abuser to be able to access the person at risk through use of a court order
- Criminal prosecution
- Blocking nuisance calls

5.2.6 Principle 6: Visibility or surveillance

Making sure people would be visible if they carried out abuse or neglect. This can involve

- Natural surveillance, improving lighting or moving an activity to somewhere where it can be more readily seen by others
- Formal surveillance, such as using alarm systems or CCTV
- Informal surveillance, which involves encouraging people to be vigilant and know what to do when they see a potential risk, or setting up groups such as a neighbourhood watch or a group for service users and relatives in a care home

5.2.7 Environmental design

Changing the environment of a building or site to reduce opportunities for abuse or neglect

5.2.8 Rule setting

Introducing ways of behaving, policies, procedures, codes of conduct and so on which set out what is acceptable behaviour, such as

- setting an expectation that ID badges will be worn, or
- visitors to a place registering when they arrive and leave
- Family work to agree changes to behaviour that harms.

5.2.9 Increase the chance of being caught

Anything that slows down an abuser or increases their risk of being caught, such as maintaining and monitoring alarm systems or CCTV

5.2.10 Deflecting abusers

Diverting potential abusers from committing abuse. This can involve

- working with people to influence standards, thinking and attitudes
- Improving training and supervision arrangements
- Reassessing and changing support provision for an adult with care & support needs who poses a risk of harm to other service user/s
- Carrying out a carers assessment and providing services to decrease risk of harm
- Meeting with an individual who poses a risk of harm, and negotiating changes to their behaviour

5.3 Securing justice

Actions that can help secure justice include

- Criminal investigations by the Police
- Health and Safety investigations and prosecutions
- Prosecutions by Trading Standards
- Enforcement action by regulators or professional bodies
- Applications to the Court of Protection or High Court
- Civil injunctions
- Applications for criminal injuries compensation
- Restorative justice

6 Using the RASCI model to plan roles and responsibilities

6.1 The RASCI model

The RASCI model can help clarify roles in a project such as a safeguarding enquiry. For each task involved, identify who is responsible, accountable, or supportive of the work and who is to be consulted, and to be informed

- **Responsible**: The person or stakeholder that leads the doing of the work. They must complete the task or objective or make the decision. There must be one and only one R. R has an integration role and is directly accountable for quality of decisions. This person ensures that the task is completed effectively and handed over for sign off for approval by A to move on to the next step.
- **Accountable**: Person or stakeholder who is the "owner" of the task. He or she must sign off or approve when the task, objective or decision is complete. This person must make sure that responsibilities are assigned in the matrix for all related activities. There can be more than one A, but the aim is always to have as few as possible, since all A's must approve every action that takes place. This person coaches, provides feedback, adds value, provides direction, sets overall terms of reference and is ultimately accountable for overseeing the implementation.
- **Supporting**: The person or team of individuals who are needed to do "the real work."
- **Consulted**: People or stakeholders who need to give input before the work can be done and signed-off on. These people are "in the loop" and active participants, and the communication with them is two-way. C's input should be obtained before a decision is made, though it may not necessarily be used.
- **Informed**: People or stakeholders who need to be kept "in the picture." They need updates on progress or decisions, but they do not need to be formally consulted, nor do they contribute directly to the task or decision. They should be advised after decisions have been made to avoid being sucked into the decision making.

6.2 Example of using the RASCI model

For example: A safeguarding concern arises when a person who lives in a care home arrives at hospital by ambulance. The person is in a somewhat unkempt state, and the ambulance crew say this was the condition they were in when they arrived at the care home. They also mention that there were delays both with the response from the ambulance service to the call from the care home, and once they arrived at the hospital with A&E being able to receive the person from the ambulance. A couple of hours after they have arrived at hospital, staff and A&E notice that the person has pressure ulcers. The hospital staff make a safeguarding referral to the local authority, noting there is the potential that the pressure wounds could be associated with possible neglect at the care home, by the ambulance service, or the hospital. A RASCI matrix for the likely steps involved in responding to such a situation might look like this

	Person at risk	Local Authority: SAM role	Local Authority: LEO role	Hospital	Ambulance Service	Care Home	Healthcare Commissioner	Social Care Commissioner	CQC
Immediate risk management	C	A	R	S	S	S	I	I	I
Deciding what the safeguarding enquiry will involve	S	A	R	C	C	C	C	C	I
Undertaking the safeguarding enquiry	C	A	R	S	S	S	S	S	I
Developing the safeguarding plan	S	A	R	C	C	C	C	C	I
Implementing the safeguarding plan	S	A	R	S	S	S	S	S	I
Reviewing the safeguarding plan	S	A	R	S	S	S	S	S	S

7 Relationship to other processes

It may be necessary to consider whether the safeguarding enquiry meets the criteria for other investigations and reviews, such as

- Criminal Investigations (see section in Adult safeguarding and criminal investigations)
- Serious Incident Investigations (see section on adult safeguarding and concerns relating to services)
- Child Protection and Safeguarding Procedures
- Reviews/investigations which may be undertaken following the death or significant injury of an individual
- Safeguarding Adults Reviews
- Serious Case Reviews concerning children

7.1 Child Protection and Safeguarding Procedures

If there are concerns about a child as well as an adult safeguarding enquiry, the Lead Enquiry Officer should link with the Children's Services to agree any co-ordinated actions in line with both Surrey Safeguarding Children's Board Policy and Procedure, Surrey Safeguarding Adults Board Policy and Procedure, and SCC Adult Safeguarding Policy and Procedure.

7.2 Reviews/investigations which may be undertaken following the death or significant injury of an individual

It is likely that a safeguarding enquiry would precede any decision making about the reviews below being undertaken, and information for safeguarding enquiries undertaken for that individual, or other affected individuals, may be shared as part of the review process.

7.2.1 Safeguarding Adults Reviews

Safeguarding Adults Reviews (SARs) are a statutory duty under the Care Act for Safeguarding Adults Boards to undertake. This is when:

- an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- an adult is still alive but has experienced serious neglect or abuse and there is concern that partner agencies could have worked more effectively to protect the adult.

For further information please see Surrey Safeguarding Adults Board's Policy and Procedure

7.2.2 Serious Case Reviews concerning children

Local Safeguarding Children's Boards undertake reviews of serious cases in specific circumstances, such as the death of a child where abuse or neglect are known or suspected, and advise on lessons to be learned.

Refer to the Surrey Safeguarding Childrens Board Procedures for more information.

7.2.3 Domestic Homicide Reviews

Domestic Homicide Reviews are statutory reviews, reviewing the circumstances in which the death of a person aged 16 or above appears to have resulted from domestic violence and abuse.

7.2.4 Coroner Investigations

Coroners investigate deaths that have been reported to them if it appears that: the death was violent or unnatural; the cause of death is unknown, or the person died in prison, police custody, or another type of state detention. In these cases coroners must investigate to find out, for the benefit of bereaved people and for official records, who has died and how, when, and where they died.

If it is not possible to find out the cause of death from a post-mortem examination, or the death is found to be unnatural, the coroner has to hold an inquest. An inquest is a public court hearing held by the coroner in order to establish who died and how, when and where the death occurred. The coroner or jury also makes findings to allow the cause of death to be registered, such as 'accident or misadventure', 'natural causes', 'unlawful killing', 'suicide' or an 'open' verdict. The coroner or jury may also make a brief narrative conclusion setting out the facts surrounding the death in more detail and explaining the reasons for the decision.

Click here for a short guide to Coroner Investigations.

7.2.5 Multi Agency Public Protection Arrangements (MAPPA) Serious Case Reviews

If an offender subject to MAPPA commits a Serious Further Offence a MAPPA Serious Case Review is to be undertaken. The purpose of the MAPPA Serious Case Review is to examine whether the MAPPA arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.

Please refer to the MAPPA Guidance for further information.

7.2.6 Mental Health Homicide Reviews

NHS England is responsible for commissioning independent investigations into homicides (sometimes referred to as mental health homicide reviews) that are committed by patients being treated for mental illness. Mental Health Homicide Reviews are undertaken under the NHS England Serious Incident Framework.

7.2.7 Learning Disabilities Mortality Review (LeDeR) Programme

The LeDeR programme has been established to support local areas to review deaths of people with learning disabilities, and to use the lessons learned to make improvements to service provision. All deaths of people with a learning disability, aged 4 years and over, may have an initial review, regardless of whether the death was expected or not.

Click on this link for the LeDeR programme for further information or contact your Clinical Commissioning Group Safeguarding Team and/or Local Area Contact for LeDeR.

7.3 Complaints processes

As safeguarding adults work has progressed, so has the understanding of how to better respond to the complexities that the situations involve. For example, practice has sometimes been adopted in which where there was a situation that was both a complaint and a safeguarding adults concern, the rule has been that the complaints process would always be suspended until the adult safeguarding work is completed.

This approach has not always help achieved the outcomes needed. Some sectors, such as adult social care and health services, have prescribed complaints processes which are at odds with this approach. It has also resulted in inefficiencies

- Complaints processes can be effective at establishing the facts and securing redress for people when things have gone wrong. By putting these outside of the safeguarding adults process, the opportunity to get the best out of both processes working together has been lost
- The risk is created that a concern about decision making about the local authority's adult social care services will go through a safeguarding adults process instead of a complaints process, which is at odds with the regulatory arrangements for adult social care complaints
- It risks creating a perception that a concern is either a safeguarding adults concern or a complaint, whereas many issues would correctly be identified as both
- A more flexible approach to the relationship of safeguarding adult and complaints processes may be useful. The person responsible for managing a particular enquiry will choose the best approach for the circumstances in front of them. They will make this choice in partnership with others and based on the merits of the particular situation.

Broadly speaking, the options that might be used are

- Suspend the complaints process until after the adult safeguarding process. This might be used, for example, where the person making the complaint was the person who may have

caused harm, and to pursue the complaint may compromise the safeguarding adult process from achieving its aims of establishing facts and protecting the adult at risk

- Use the complaints process to achieve some or all of the enquiry. Adult safeguarding processes and complaints processes both include the aim of establishing facts. In some circumstances, it is best to combine the work that will achieve this aim. This can be achieved in a variety of ways, which will be negotiated on a case-by-case basis by the person overseeing the enquiry and the partners involved in the process. It could relate to the complaints process(es) of any partner(s) involved in the piece of adult safeguarding work

7.3.1 Complaints about the adult safeguarding process

If a person using services, or someone affected by those services, has a complaint about how a safeguarding adults enquiry has taken place then this is likely to fall within the complaints regulations for adult social care.

However, there will be other concerns that crop up that can't be covered by adult social care complaints regulations, such as concerns raised by partner organisations of the SAB. Local arrangements should set out expectation for how those involved in adult safeguarding processes to be able to raise concerns about a process they have been involved in.

Taking account of the context of the adult safeguarding concern

8 Thinking about adult safeguarding enquiries in context

When carrying out an adult safeguarding enquiry it can be helpful to consider the context of that adult safeguarding concern. Doing this can help clarify things like what issues we need to pay attention to, who needs to be involved, and what aims we might have.

Broadly speaking, adult safeguarding concerns arise in one of three contexts

- Within private and family life
- Within the wider community or other social context
- Within service provision, particularly health and social care services

Some might say that self-neglect is a fourth context but as Surrey Safeguarding Adults Board has adopted an approach that our starting point is that an adult safeguarding enquiry is not the response we will give to concerns about self-neglect, this will not be covered here.

Some concerns might span more than one context. This is sometimes a clue that more than one concern has become conflated, so it would be better to separate them out, but there are issues that cross more than one context. Using this model to consider each context in turn can help with being clear about what issues are at play for each context, and therefore what actions you might want to take.

8.1 Examples of concerns in different contexts

8.1.1 Concerns regarding issues in private and family life

For example:

- Concerns that the family of a person with profound and multiple disabilities who is unable to make decisions about their own care are not ensuring they receive the health care that they should are not ensuring that the person gets the health care that they should
- Concerns that the son of a person with dementia is taking money from them to pay for their own alcohol and drug use

In a case such as where there are concerns that the family of a disabled person are not ensuring they receive the healthcare they need, the adult safeguarding work might involve:

- **Enquiry**: This will be likely to include reviewing what has happened so far to see whether there is substance to the concerns, to share the concerns with the family and get their views, to review whether the work done with the person and their family so far has properly dealt with these matters, and to work out what are the root causes of any problems identified.
- **Safeguarding plan**: This is likely to involve a plan of a graduated steps of measures to ensure the person receives the health care they need, such as working with the family to be clear

about what is needed, to more assertive approaches if that is not successful such as taking the matter to the Court of Protection.

8.1.2 Concerns regarding community safety issues

For example:

- A person with learning disabilities being a victim of "mate crime", where people exploit them under the guise of friendship
- The home of an older person with memory loss and alcohol use issues being taken over by a gang

In a case such as where there are concerns that a person with learning disabilities being a victim of "mate crime", the adult safeguarding work might involve:

- **Enquiry**: To establish what has happened, and what the adult wishes to have happen. There can be particular challenges in such cases as the person may not recognise the risks they are facing or, perhaps, will be ambivalent about the relationship with the person who may be abusing them as they see it as beneficial as it is harmful.
- **Safeguarding Plan:** This may consist of measures to help the person protect themselves both in the short-term such as considering ways the person's finances are managed if they need support with this, and in the longer term such as building the person's skills to manage friendships and creating opportunities to make more positive relationships. Multi-agency work might be needed to address those causing harm such as the police addressing any criminal issues, and housing providers and others using powers available to them.

8.1.3 Concerns arising within service provision

For example:

- A person in a care home has unexplained bruising
- A person with learning disabilities is admitted to hospital with a broken leg. While they are there, their epilepsy and diabetes are poorly managed
- A solicitor undertaking extended and expensive work for a person with a brain injury who doesn't have the capacity to make a decision to instruct the solicitor

In a case such as where there are concerns that a person in a care home is not receiving the care that they should, the adult safeguarding work might involve:

- **Enquiry**: Establishing what has happened and what the root causes are. Some instances might be caused by poor practice by an individual, whereas others could be due to broader issues such as poor recruitment or training of staff, or low staffing levels
- **Safeguarding plan**: There may need to be steps to manage immediate risks to the person and to others using the service. Evidence of the issue and the root causes may be passed over to the commissioners and / or regulators of the service

9 Safeguarding adults enquiries in the context of private and family life

9.1 Typical scenarios

Typical safeguarding adults concerns that arise in the context of private and family life include

- Domestic abuse: This might involve
    - Abuse within the context of an intimate partner relationship such as spouses, civil partners and cohabitees
    - Between parent and adult child
    - Other family relationships such as siblings
    - Coercive and controlling behaviour
- Financial abuse by a family member
- Not providing the care that a loved one needs
- Not acting in the best interests of a family member who is unable to make a decision for themselves

9.2 Applying the Surrey Safeguarding Adults Enquiries Method (SSAEM)

9.2.1 Decide

Concerns may not have an easily identifiable starting point. They may slowly emerge over time, so those involved may "slide" in to them without recognising them.

9.2.2 Plan

Safeguarding adults work in the context of private and family life can be some of the most complex cases, particularly where there are complexities about emotional and psychological issues.

The adult may want those who pose a risk to be involved in the planning of the enquiry and identifying the outcomes to be achieved.

9.2.3 Do

There must be a presumption that the person who presents a risk must be involved in the enquiry, to comply with natural justice principles

Safeguarding plans might involve

- Improving skills
- "Target hardening"

If the root cause is the relationship, then that may need to be the focus of intervention. What skills would better help these people manage this relationship?

9.3 Making Safeguarding Personal in this context

Typical challenges that can arise are

- The adult being ambivalent about recognising the risks they face, which impacts on their ability to recognise and act on the risks they are facing
- People having complex relationships in which vulnerability to abuse from another person arises in the context where there may be complicating factors such as dependency, or alongside positive aspects to the relationship.

9.4 Human Rights considerations

There are important human rights considerations in this context

9.4.1 Consult the adult

The person must be consulted about what we are doing and any actions we plan that may affect them

9.4.2 Consulting with others

We must consult with others when

- The adult wants us to
- The actions we are planning may impact on their private and family life
- Where the adult lacks capacity to make relevant decisions, and these are people we should consult as they have an interest in the welfare of the person

This will be true even if the person we should consult with is the source of risk to the adult. It can be difficult and challenging to do this but, unless we can establish an overriding reason not to, we must.

The principles of natural justice mean we must give a fair hearing to the person we think may be the source of risk to the adult.

9.5 Mental capacity considerations

Concerns may arise that a person who is unable to make decisions about how to protect themselves from the risk of abuse or neglect within their private or family life. Appendix C sets out a graduated approach that can be useful in such circumstances.

9.6 Involving other agencies

9.6.1 Domestic abuse

People experiencing domestic abuse may benefit greatly from the involvement of specialist domestic abuse services.

It can be important when working with colleagues in such circumstances to be aware of some differences in ways of working. Many domestic abuse services focus their work on the victim, and they will not work with the perpetrator of the abuse.

However, in safeguarding adults work there will be circumstances where there has to be work with the perpetrator. That may be because of the human rights or mental capacity issues mentioned above, or it is because that person has a role in providing care to the person. This can add a layer of complexity to multi-agency working. It is not impossible for good joint work to take place, but it requires the differences in approach to be recognised and discussed, and the implications taken account of when planning together what will be done.

9.6.2 Children's social care

If there are risks to children, there should be involvement of children's social care.

9.7 Working with uncooperative families

Uncooperativeness can often come in different forms

- Ambivalence: such as being late for appointments or avoiding uncomfortable topics
    - Everyone can be ambivalent at times
    - May reflect where they are at in a process of change
    - May reflect cultural difference, uncertainty of expectations, or poor previous experiences
- Avoidance: such as avoiding appointments or cutting meetings short
    - May have a difficulty
    - May have something to hide
- Confrontation: such as challenging professionals or extreme avoidance
    - May be based on fears and suspicions
    - Needs to be confronted consistently
- Violence
    - Deep and longstanding fears and hatred
    - May be limited capacity for change

Where hostility towards most agencies is experienced, this needs to be managed on an inter-agency basis otherwise the results can be as follows:

- Everyone 'backs off';
- The family is 'punished' by withholding of services as everyone 'sees it as a fight';

- There is a divide between those who want to appease and those who want to oppose - or everyone colludes.

Effective multiagency working is more likely where everyone is

- Aware of the impact of hostility on their own response and that of others;
- Respectful of the concerns of others;
- Alert to the need to share relevant information about safety concerns;
- Actively supportive of each other and aware of the differing problems which different agencies have in working within these sorts of circumstances;
- Open and honest when disagreeing;
- Aware of the risks of collusion and of any targeting of specific professions / agencies;
- Prepared to discuss strategies if one agency is unable to work with a family. In circumstances such as these, professionals in the multi-agency network must to agree whether or not it is possible to gather information or monitor the well-being of the person at risk, and ultimately whether it is possible to have a truly multi-agency plan?

Things that can help effective work where there is a lack of cooperation

- Keep the relationship formal though warm, giving clear indications that the aim of the work is to achieve the best for the person at risk;
- Clearly stating their professional and/or legal authority;
- Continuously assessing their motivations and capacities of the family to respond co-operatively in the interests of their adult at risk
- Confronting uncooperativeness when it arises, in the context of improving the chances of a favourable outcome for the adult at risk
- Engaging with regular supervision from their manager to ensure that progress is being made and is appropriate;
- Seeking advice from experts (e.g. police, mental health specialists) to ensure progress is appropriate;
- Helping the family to work through their underlying feelings at the same time as supporting them to engage in the tasks of caring for the adult at risk;
- Being alert to underlying complete resistance (possibly masked by superficial compliance) despite every effort being made to understand and engage;
- Being willing, in such cases, to take appropriate action to protect the adult at risk (despite this action giving rise to a feeling of personal failure by the professional in their task of engaging the family).

Things to avoid

- Seeing each situation as a potential threat and developing a 'fight' response or becoming over-challenging and increasing the tension between the professional and the family.
- Colluding by accommodating and appeasing them in order to avoid provoking a reaction;
- Becoming hyper alert to the personal threat so the professional becomes less able to listen accurately to what the adult is saying

- 'Filtering out' negative information or minimising the extent and impact of it in order to avoid having to challenge. At its most extreme, this can result in professionals avoiding making difficult visits or avoiding meeting with those adults in their home, losing important information about the home environment –
- Feeling helpless / paralysed by the dilemma of deciding whether to 'go in heavy' or 'back off'.

9.8 Risk assessment

9.8.1 Domestic abuse

There are some standardised assessment tools available, and there may be expectations about their use. For example, there is an expectation that the SafeLives DASH tool will be completed for all domestic abuse cases that adult social care has an involvement in, and it is also used as part of the process for determining whether a referral to MARAC is required.

9.8.2 Risk of abuse by a carer

Research identifies risks of harmful behaviour, whether intended or not, by a carer being greater where the carer:

- has unmet or unrecognized needs of their own
- are themselves vulnerable
- has little insight or understanding of the vulnerable person's condition or needs
- has unwillingly had to change his or her lifestyle
- are not receiving practical and/or emotional support from other family members
- are feeling emotionally and socially isolated, undervalued or stigmatised
- has other responsibilities such as family or work
- has no personal or private space or life outside the caring environment
- has frequently requested help but problems have not been solved
- are being abused by the vulnerable person
- feels unappreciated by the vulnerable person or exploited by relatives or services

9.9 Meaningful intervention

Where there is ambivalence or resistance to recognising or addressing the risks, it can be useful to consider a model such as Prochaska and Di Clemente's work on the psychology of change. It can give an insight into where people's thinking is at, and it can guide the selection of useful ways to intervene. This can help those in the services involved to avoid feelings of helplessness in difficult situations, and to focus on useful interventions which can have a significant long term benefit even if there is little apparent change in the short-term.

For example, if the safeguarding concern has arisen from others but the adult is apparently oblivious or unconcerned about the risks they face, then using the model might lead to the interpretation that the person is in the “pre-contemplative” stage. The model would suggest that interventions that raise cognitive dissonance might be the most useful. That might be as straightforward as saying to the person that you don’t share their perception of the situation, and providing information about their options for support should they change their mind.

10 Safeguarding adults enquiries in the context of community safety

10.1 Typical scenarios

Safeguarding concerns that involve community safety issues include

- Mate crime
- Anti-social behaviour
- "Magpie" issues: where adults with care and support needs find their homes being taken over by others. Sometimes, this will be connected to substance misuse issues or to gang activity.
- Hate crime
- Neighbour disputes

10.2 Applying the Surrey Safeguarding Adults Enquiries Method (SSAEM)

10.2.1 Decide

The concerns might first come to the attention of services such as the emergency services or housing related support, or to members of the public such as family members or neighbours. Their primary focus may be on tackling the community safety elements or the behaviours of the person(s) who is the source of risk, and they may be less familiar with adult safeguarding issues. Ensuring that those in such roles are looking out for safeguarding adults concerns and know how to act on them can be of particular importance.

10.2.2 Plan

Safeguarding adults work in this context will be likely to undertaken in the context of multi-agency approach, and which overlaps with other processes. For example, there may be criminal investigations, tenancy enforcement issues or use of measures to address anti-social behaviour. Establishing the facts will be an area where the safeguarding adults enquiry might overlap with these processes, so planning the safeguarding adults enquiry will involve getting clarity on who will do what, in what order, when and how, in order to minimise duplication and avoid different strands of the work "tripping over" one another.

10.2.3 Do

It is important that the adult safeguarding enquiry keeps its identity in the midst of other processes that can be going on. It needs to keep its focus on the adult with the care and support needs, what they are experiencing, and the outcomes that they want. It can be important to focus on the Making Safeguarding Personal principles, so as to avoid the safeguarding adults enquiry becoming distracted by the other issues and processes involved.

The effectiveness of safeguarding adults work where there are community safety issues can depend on how well the range of powers to intervene that sit with a broad spectrum of services are understood and used. Working with others to carry develop the safeguarding plan will be essential. Good safeguarding planning will often involve multi-agency work with a shared problem-solving approach.

The focus can be on reducing the risks to the person by

- Actions in regard to others that reducing their opportunities to pose a risk to the adult
- Actions with the adult that reduces their exposure to risk
- Actions with the adult that improves their ability to manage risk. Using the concept of "target hardening" from the criminal justice sphere can be useful.

11 Safeguarding adults enquiries in the context of service provision

11.1 Typical scenarios

Safeguarding concerns in the context of service provision include

- A person living in a care home who is visited by someone who pressurises them into handing over money
- A hospital that fails to make reasonable adjustments when meeting the needs of a person with a learning disability when they are an in-patient for surgery
- A home care service that fails to provide the care someone needs
- A person living in a care home reports being handled roughly and has injuries. There have been several similar concerns at the same care home recently.

11.2 Applying the Surrey Safeguarding Adults Enquiries Method (SSAEM)

11.2.1 Decide

In many instances, the service itself will be making the referral to the local authority. Many concerns arise in the context of health and social care services, and services in this sector have expectations on them about having staff with the ability to recognise and act on such issues, and having robust processes to respond to such concerns. The Care and Support statutory guidance sets out clear expectations on regulated service providers to respond effectively to safeguarding concerns in their organisation, and to involve the local authority so that it has oversight of the situation.

Concerns will arise outside of the health and social care sector, where there may be less familiarity with the issues. Local authorities may have more of a role to raise awareness in such services, and may need to do more to support them with managing the response when concerns arise, in comparison with health and social care services.

There will be instances in which the concern is reported to the local authority rather than to the service itself. The usual expectation should be that the local authority will ensure there is early involvement of the service.

11.2.2 Plan

Looking in to and making sense of what has happened within a service may require some experience or expertise about such services. This will inform the decision about who is best placed to undertake the safeguarding adults enquiry.

An expectation of the Care and Support statutory guidance is that services will have processes in place for responding to concerns. In many instances, the enquiry plan will involve the local authority and the service determining how this will be put in to practice in

the particular instance, and that most or all the activity involved will be undertaken by the service.

However, where the concern touches on more than one service there may be more of a role for the local authority to lead and coordinate matters. For example, where a concern about poor patient care in a hospital arises, the safeguarding adults enquiry may consist mostly or wholly of a clinical governance process such as a Serious Incident investigation. However, where the concern spans the person's experiences prior to admission at the care home they live in, their ambulance journey to hospital, and the care they received once arriving at hospital, it is clear that a single agency's Serious Incident investigation will not be sufficient.

The Care and Support statutory guidance also mentions that there will be circumstances where it would not be desirable for the service to undertake an enquiry itself, such as where there would be an actual or apparent conflict of interest, or where there were grounds for concern about its capacity or capability to do so.

Where the concern relates to the risk of abuse or neglect by a health or social care provider, it will be good practice for the MASH to contact the locality team where that provider is in order to discuss the concern with them so decision making can be informed by local knowledge of that provider.

11.2.3 Do

Where an enquiry involves coordinating other processes such as a complaints process, an organisation's Incident Management, or a health service's Serious Incident process, the need for ongoing communication is paramount in order to keep the various strands on track and avoid duplication or drift.

It is also important to keep the adult informed about what is happening.

An effective way to keep things on track is to share drafts of the enquiry report with all those involved as the enquiry progresses. That allows early resolution of gaps, anomalies and misunderstandings, and helps build a shared understanding of how the enquiry is progressing and what is emerging.

A complicating factor can be where a safeguarding enquiry relates to issues that may require action by an employer such as an investigation under disciplinary processes. There will be particular considerations around information sharing issues, and ensuring all processes are undertaken fairly.

For example, where a safeguarding adults concern and a disciplinary investigation overlap, options might include

- A brief safeguarding enquiry, followed by a safeguarding plan which includes the employer taking in to account the findings of the enquiry when considering what action, if any, may be required in relation to employees.

- The disciplinary investigation contributing to the safeguarding enquiry, but being treated as something of a “closed box”; only information essential to the safeguarding enquiry would be shared with it from the disciplinary investigation.

The Care and Support statutory guidance says that a key role for the local authority is to quality assure any safeguarding adults enquiry work undertaken by others. If it is not up-to-scratch, the local authority should not accept it. If the problems cannot be remedied, then the local authority may need to undertake the enquiry itself.

When it comes to the Safeguarding Plan, in the first instance it will fall to the service provider to address any identified issues with service provision. If the enquiry has involved processes such as a complaint process or Serious Incident, then these may have identified some or all of what is required by means of remedy and / or addressing root causes.

11.3 Requesting a contribution to an enquiry from a service provider

When requesting a contribution to an enquiry from a service provider, it is usually best to consult with them about what may be required and negotiate matters such as

- What is required?
- When, how and who they will report back to?
- Expectations about providing progress reports or alerting where there are difficulties which may impede progress
- Whether the information provided needs to be a bespoke piece of work or can wholly or in part be made up of already available material, such as internal incident or investigation reports

11.3.1 Information to give the service provider

The SAD should ensure that the service provider is given the information they need in order to give a good quality contribution to the enquiry. Typically, this will include

- Details of the Safeguarding Concerns
    - Detail each concern separately
    - Be specific. Give date(s), time(s), place(s) of alleged incident or information about the nature of the risk
    - Give the names of those involved in the alleged incident
    - Summary of initial action taken at the point of the concern being raised
    - Summary of discussion with the adult or their representatives

- Scope of the Enquiry
    - What hypotheses, or possible explanations for the concern, do you need the service provider to consider?

- Who do you require to undertake the enquiry? Is there anyone that you do not want to undertake the enquiry as, for example, they may have or appear to have a conflict of interest.
- What information do you require the service provider to include in their enquiry? For example, are there particular records that should be included or particular people that they should speak to?
- Any particular contextual issues that need to be taken in to account
- How should the adult or their representative be involved in the enquiry?
- What outcomes does the adult want from the enquiry?
- Who will the enquiry report be shared with? Are there any information governance issues that need to be considered?

- Enquiry process
  - When is the report due, and where should it be sent?
  - Who should receive drafts of the report and be given an opportunity to comment? How will the adult or their representative be involved in this?
  - What are the sign-off arrangements for finalising the report? How does any internal assurance process align with the SAM needing to accept the report before it is finalised?

11.3.2 Information the service provider report might include

Typically, a report from a service provider might include the following

- Background Information
  - Information about the adult
    - What are their care and support needs? How do these impact on their ability to protect themselves
    - Relevant background information
    - Any history of being at risk of or experiencing abuse or neglect
    - Any relevant information about their relationship to the person(s) or organisation that is the source of risk
  - Information about the person(s) or organisation(s) who are the source of risk
    - Who or what are they?
    - What is their involvement with the adult?
    - Any relevant background information, including any previous adult safeguarding concerns and whether abuse or neglect was established by any previous adult safeguarding enquiries
    - Any other relevant information
  - Do the concerns involve risks to other people with care and support needs?
- Any relevant background information about these types of risks which has not been covered above, such as similar situations involving a different adult, or where different person(s) or organisation(s) were the source of the risk

- Method
    - Detail any documents that were used, and how they were selected
    - List of people spoken to or otherwise consulted, and how they were selected
    - Details of information used from other strands of the enquiry or any other sources of information and research
    - For a more complex enquiry, a chronology of what was done to look in to the matters may be useful

- Findings
    - If the report covers more than one concern, deal with each safeguarding concern separately
    - Any relevant information from
    - What facts have you established, on balance of probabilities? For a more complex enquiry, a chronology of what happened may be useful

- Analysis of the evidence and recommendations
    - Is the evidence relevant, reliable and corroborated? You may want to comment on this for each piece of evidence, or at least for any key pieces that significantly inform the judgments you are making.
    - Are there any gaps, discrepancies or inconsistencies in the evidence that you have? If so, what has been done to resolve these?
    - Did the adult experience or was at risk of abuse or neglect?
    - If so,
    - Were there any aggravating or mitigating factors?
    - What were the immediate and the root causes of this?
        - What corrective actions have been taken? Are there any that you recommend should be taken?
        - What preventative actions have been taken? Are there any further actions that you recommend should be taken to prevent something similar happening again?
    - What has been the impact on the person?
        - What is their view on the impact on them and what needs to happen next
        - What is your view of what protection and support the person may need?
        - What has been done in order to redress the situation for the adult? Are there any further actions that you recommend should be taken to secure redress, resolution, recovery or justice for the person?
    - What follow-up action has been taken with regard to the person or organisation responsible for the abuse or neglect? Are there any further actions that you recommend should be taken? These might include HR processes, a referral to the Disclosure and Barring Services, or a referral to a professional body or regulator
    - Are there any other actions needed?

- Should there be a referral to the Safeguarding Adults Board for consideration of a Safeguarding Adults Review for this matter? Give reasons for your answer.

- Any other issues: You might also include matters such as
  - Any learning identified for adults, families, and your organisation or for others
  - Any systems, processes and quality issues that need to be addressed including training needs and how this will be med
  - For CQC regulated providers, how the duty of candour has been or will be met, if relevant
  - How you have or will feedback to the adult, their family and representatives
  - How you have or will feedback to contractors, commissioners or regulators of your service, if needed
  - Any action plan for your service, with timescales for completion

11.4 Analysing risks relating to social care provider

The University of Hull has produced research on indicators of risk in social care provider services. At appendix A, a tool can be found which is based on this research that can help to analyse the risks relating to social care services.

11.5 Safeguarding adults work in service provision: neglect and negligence

Section 42 of the Care Act tells us that safeguarding enquiries are concerned with abuse and neglect. This can be problematic when a safeguarding concern touches on issues or concerns where the term "neglect" might have specific meanings or connotations.

For example, a safeguarding concern relating to the quality of practice within a health service will, in safeguarding adults enquiry terms, be concerned with whether there was neglect or not. However, in this context there will be other meanings of "neglect", and these multiple meanings and contexts can be problematic. A finding from a safeguarding enquiry that there has been neglect could have consequences if it is read across to other contexts

- A finding that there has been neglect by an individual: The issue of neglectful practice could have consequences for the person's employment, or for their professional registration
- A finding that an organisation has been neglectful: This could have consequences for the organisation's reputation, or potentially be seen to be an admission of liability of negligence which could open the way to legal action

If the issues of these different meanings and contexts of "neglect" is not managed, it can lead to ineffective and / or fractious safeguarding adults enquiry processes in which the task of making a finding of whether there has been neglect or not becomes impossible, because the risks this poses to some people or organisations means they resist a finding being made.

A way of managing this issue is to include in any report for the adult safeguarding enquiry a statement along the lines of

> *"Safeguarding adults enquiries have to take account of s42 of the Care Act and the Care and Support statutory guidance, and the reporting requirements of NHS Digital. These require us to apply particular labels to the concerns.*
>
> *Where these relate to issues of possible poor practice, then the most appropriate of the categories on offer may be "Neglect" or "Organisational abuse". The intention of using these categories is to focus attention on learning the right lessons, and for the production of aggregated statistics.*
>
> *This should not be confused with saying there is any culpability of a particular individual, or that the safeguarding enquiry is a determination of liability. Those are issues for the usual processes of the organisation(s) responsible for the services in question to address such matters."*

11.6 Safeguarding adults work, commissioning and contract management, and quality assurance

Safeguarding adults concerns will, in some instances, relate to concerns whether the delivery of a service has been abusive or neglectful or has risked being so. Sound safeguarding adults work will

- Help with making judgements when concerns arise about what has happened and why
- Inform decisions about putting in place measures to prevent future problems
- Identify where things are working well and where risks are increasing

A number of reports and studies, such as the Equality and Human Rights Commission's "Close to home" report on home care services, have emphasised the links between good commissioning practice based on human rights and dignity in care, and the prevention and effective response to abuse and neglect. Though these have mostly been in the areas of health and social care services, the principles can be applied more widely.

11.6.1 Making judgements

Good commissioning arrangements can include expectations on service providers around

- Recognising and reporting concerns about abuse and neglect and the risk of these
- Expectations about their cooperation with and involvement in safeguarding enquiries
- Benchmarks for what is acceptable practice, so that it is possible to say whether the issues that have caused concern fall above or below the expected standards

A lesson from the Francis report is that assurance must be more than checking that systems are in place. There must be meaningful measurement of outcomes and user experience.

Commissioning arrangements should build in expectations that lessons learned from safeguarding enquiries or reviews will be put in to practice. There should be good arrangements for sharing these lessons, deciding what needs to change, and for those commissioning and delivering services to work together to put these in to action.

11.6.2 Safeguarding enquiries, commissioning and contract management, and quality assurance

As with many other areas, what will happen in any particular situation will be a matter of case-by-case negotiation as those directly involved will be best placed to decide what is best in the particular circumstances.

The general principles are

- The employer has the primary responsibility for enquiring in to what has happened and, where things have gone wrong, taking any actions necessary to put things right and prevent reoccurrence
- Adult Social Care staff may be involved in actions that involve dealing with the adult, their carers, and friends, family and so on that it is relevant to involve
- Surrey County Council and / or CCG Commissioning and Contract Monitoring staff , or the Quality Assurance Team may be involved in actions dealing with the provider service, accessing records and so on
- There is no strict demarcations over allocation of tasks. Decisions should be made on a case-by-case basis and take in to account who is available to carry actions in a timely manner

11.6.3 Safeguarding planning, commissioning and contract management

Safeguarding enquiries are about the adult who has experienced or been at risk of abuse or neglect. Safeguarding plans should address the issues for that adult.

Sometimes safeguarding concerns will through up issues that are wider than just the one adult's experience or can be addressed through a safeguarding plan for that adult. Examples would be

- Where there are a pattern of issues arising for several people using the service
- Where the issues of concern may lead to other processes to address them, such as disciplinary process or contract management actions, which it would not be appropriate for the adult to be involved in and which fall outside of the s42 Care Act processes

In such circumstances, it may be enough for the safeguarding plan simply to identify how what has been learned from the safeguarding enquiry will be passed to those other processes.

11.7 Safeguarding enquiries, other processes and provider-level concerns

Where there are wider concerns about a provider service which it is not appropriate to deal with through a s42 safeguarding adults enquiry, because of the nature of those being focused on the one adult, options for how the wider concerns might be addressed are

- Through a Quality Assurance led process, which can involve multi-agency elements where needed, such as working with regulators of a service
- Through a single-agency or multi-agency management review, likely to be led by the commissioners of the service
- Through a Safeguarding Adults Review process, if the duties for one have been triggered or if Surrey Safeguarding Adults Board considers it useful to have one in the circumstances

11.8 Complaints processes in service providers and service commissioners

Some adult safeguarding concerns touching on the services provided by social care or health services or commissioned by Surrey County Council, a CCG or NHS England will also be complaints for those services. The complaint process can be the vehicle for carrying out some or all of an adult safeguarding enquiry.

Social care providers regulated by CQC are required to have a complaints processes in line with Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

NHS bodies and local authorities with adult social care responsibilities, including Surrey County Council, must have a complaints process in line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Where the complaint relates to social care provision that is commissioned by Surrey County Council, or health care provision that is commissioned by a CCG or NHS England, then that complaint may need to be responded to through the complaints process of both the provider and the commissioning organisations.

11.9 Safeguarding adults work and Serious Incident investigations in the NHS

For further detail please see NHS England Serious Incident Framework.

Serious Incidents include acts or omissions occurring as part of NHS-funded healthcare (including in the community) that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm or actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:

- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or,
- where abuse occurred during the provision of NHS-funded care.

Serious Incidents must be declared within the NHS by appropriate NHS staff as soon as possible and immediate action must be taken to establish the facts, ensure the safety of the patient(s), other services users and staff, and to secure all relevant evidence to support further investigation.

Some adult safeguarding enquiries relating to NHS services will involve matters that also meet the threshold for Serious Incident (S.I.) investigations. The guidance on Serious Incidents says that where they relate to safeguarding concerns, the adult safeguarding processes should inform the planning of the S.I. and how it will contribute to the safeguarding enquiry. The SAD and SAM should consult with the NHS service declaring the SI and their commissioning body that will oversee the SI to coordinate how the SI will contribute to the adult safeguarding enquiry.

The coordination of serious incident investigations and safeguarding enquiries requires shared understanding of each organisation's statutory and legal responsibilities, effective communication, transparency, learning and co-operation across the multi-agency safeguarding adults' partnership.

In some instances the S.I. might form the totality of the safeguarding enquiry. In others, it might just be one strand, particularly where the adult safeguarding enquiry spans across multiple organisations and beyond the NHS.

Investigations carried out under the Serious Incident Framework are conducted for the purposes of learning to prevent recurrence. As the focus of a safeguarding enquiry is different from a serious incident investigation, the findings of one do not in itself determine the conclusions of the other. The Lead Enquiry Officer for the safeguarding enquiry and the lead practitioner undertaking the serious incident investigation must plan and co-ordinate the approach and tasks within these processes.

11.10 Distinguishing between personal and organisational responsibility

Robert Wachter proposed a model to help distinguish between personal and organisational responsibility in the field of patient safety ("Personal accountability in healthcare: searching for the right balance" 2012, the Health Foundation), which can be adapted to other situations.

It involves asking a series of questions

- Is the patient safety problem being addressed important?
- Is there strong evidence that adherence to the practice decreases the chances of harm?
- Have the practitioners involved been educated about the practice and the evidence?
- Has the system been modified to make it easy to adhere to the practice, and have unanticipated consequences have been addressed?
- Do practitioners understand the behaviours for which they will be held accountable?
- Has a fair and transparent auditing system has been developed?

If the answer to all of these questions is “Yes”, then that would point toward the responsibility for an issue sitting with the individuals involved. If the answer to any of them is “No”, then that would point toward the responsibility sitting with the organisation.

12 Appendix A: Safeguarding Adults Provider Service Risk Assessment

Name of provider service		
Date of this summary		
Period covered		
Summary produced by	Name	
	Role	

Summary of Safeguarding Enquiries reviewed

LAS number	Date of safeguarding referral	Summary of concerns	What was found	Comments on quality and reliability of safeguarding work

<table>
<tr><td colspan="2">User experiences of the service

Indicators of increased risk:</td></tr>
<tr><td>Choice and control
Lack of autonomy and choice
Absence of advocacy
Communication needs not recognised or met
Lack of respect for privacy
Consent to care and treatment not sought
Experiencing a lack of security as a consequence of problems with care provision
Right to private and family life not promoted
Insufficient support with maintaining family relationships
Absence of privacy
People experience isolation
Failure to promote social inclusion
Care fails to meet needs regarding
Support with food and drink
Pain management
Personal hygiene
Cleanliness and infection control
Practical assistance</td><td>The behaviours of users of the service include
Changes
in expressed emotion
in ways or degree of communicating
in type or level of care asked for or needed
in skills
Inconsistency
Behaving differently with different members of staff
Being more relaxed or happier in a different environment
Behaviour and well-being
Engaging in self-harm
Engaging in sexualised behaviours
Having a number of physical injuries
Showing signs of fear or talking about not being safe
Some service users control or bully others</td></tr>
<tr><td colspan="2">Summary of evidence of indicators of higher or lower risk: (please give LAS references for source of evidence)</td></tr>
<tr><td colspan="2">Evidence where facts have been established</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Evidence where risks have been identified but facts have yet to be established</td></tr>
<tr><td colspan="2"></td></tr>
</table>

<table>
<tr><td colspan="2">The Service

Indicators of increased risk:</td></tr>
<tr><td>The physical environment
• A geographically isolated service
• A neglected physical environment
• Poor safety and suitability of premises or equipment

Institutional environment
• A lack of communication or cooperation with other services
• An inward looking organisation
• Defensiveness and lack of openness
• Inflexibility</td><td>Service design and responsiveness
• Service users are not given support to change inappropriate or harmful behaviours
• The agreed care is not being provided
• There are a lack of available options for service users

• There is insufficient attention to diverse need
• There is poor service design and care planning</td></tr>
<tr><td colspan="2">Summary of evidence of indicators of higher or lower risk: (please give LAS references for source of evidence)</td></tr>
<tr><td colspan="2">Evidence where facts have been established</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Evidence where risks have been identified but facts have yet to be established</td></tr>
<tr><td colspan="2"></td></tr>
</table>

Management ***Indicators of increased risk:***	
Leadership • Weak or ineffective management and leadership • Ineffective assessing and monitoring the quality of service provision • A lack of policy awareness • A lack of concern by managers about abuse • An inability to address or resolve problems Poor processes and practice regarding • Supporting staff • Responding to complaints • Management of medicines • Record keeping	Staffing • Low staffing levels or high use of agency staff • Problems with staff recruitment, deployment, and shift patterns • Inconsistency of staffing • Low levels of training • Poor staff morale • Poor communication within the organisation • A particular group of staff strongly influence how things are running • There is a strong staff clique and / or staff friendships and loyalties that extend beyond the workplace
Summary of evidence of indicators of higher or lower risk: *(please give LAS references for source of evidence)*	
Evidence where facts have been established	
Evidence where risks have been identified but facts have yet to be established	

The staff ***Indicators of increased risk:***	
Knowledge and skills • Members of staff do not understand the needs of the service users • Members of staff do not manage service users behaviours in a safe, professional or dignified way • Restraint is used frequently and as a first option before other approaches are tried • Members of staff touch people in inappropriate ways; this might be over rough or too intimate • Members of staff lack skills in communicating with or interpreting the communication of service users • Members of staff get important ideas wrong, such as choice and consent Inconsistency and lack of reliability • Members of staff tell different stories to explain something that has happened or has not happened • Members of staff forget or are not aware of when family, friends or professionals are due to visit • Tasks requested by professionals are forgotten or incorrectly carried out • Service users attend appointments with professionals at the wrong time/without appropriate paper work/accompanied by different staff members	Staff values and attitudes • Neutralisation of moral concerns, such as service users being seen as objects rather than human beings • Poor attitudes and responses by members of staff to concerns of abuse • Members of staff are controlling of service users • Members of staff misuse of power, offer a lack of choice or control how the service runs • Inappropriate relationships develop between staff and service users or boundaries are not maintained appropriately • Staff exhibit signs of stress or negative attitudes to users of the service
Summary of evidence of indicators of higher or lower risk: *(please give LAS references for source of evidence)*	
Evidence where facts have been established	
Evidence where risks have been identified but facts have yet to be established	

13 Appendix B: Assessing risk regarding coercion and control

Domestic abuse, coercion and control Triad risk assessment
(drawn from "DART: Domestic abuse reference tool" produced by Dr Jane Monckton-Smith)

Area 1: Controlling personality psychology

Are any factors in the checklist below present? Yes / No	
If "Yes": please give details:	
Repeat behaviour: Is this a pattern of behaviour? Has this person behaved like this before on another occasion, or in another relationship?	Yes / No
Fixation: This is often the state of being unable to stop thinking about something or someone. Or an unnaturally strong interest in something or someone	Yes / No
Obsession: This is an idea or thought that preoccupies a person's mind, even if it is negative or damaging to them (like constant control of the victim)	Yes / No
Control: Does the person seek to control the actions, time or choices of the victim?	Yes / No
Fails to stop problem behaviours when told: Does the person keep on with the behaviour even when told to stop by anyone, including the police?	Yes / No
Likes routine and order: Does this person impose routines on their partner or family?	Yes / No
Jealous and possessive: Is the person excessively jealous? Are they concerned that their partner may leave? Do they accuse their partner of having affairs?	Yes / No
Seeks early and total commitment in relationships: Does this person speed up the beginning of a relationship? Do they seek early commitment? Move in together early?	Yes / No
Self-focused: This person sees the world only from their own perspective. They use the words "I" and "me" a lot. They may blame others for bad things that happen to them	Yes / No
Lacks compassion: Does this person fail to feel sympathy? Do they see people's problems as brought on by themselves?	Yes / No
Hypersensitive to criticism: Do they respond with anger or aggression to criticism or challenge? Do they see criticism as personal attack?	Yes / No

Area 2: Risk markers

Are any factors in the checklist below present? Yes / No	
If "Yes": please give details:	
Is there escalation?: Escalation is a sign of underlying triggers. Escalation can show increase in severity or frequency of concerning behaviours, or increasing feeling of menace and unpredictability	Yes / No
Threats to kill or to suicide: Have there been threats to kill the victim or others? Has the perpetrator threatened to kill themselves?	Yes / No
Is the victim fearful?: Is the victim concerned they could be harmed? Do they believe any threats made? Do they feel the perpetrator is capable of killing them?	Yes / No
Strangulation (choking / drowning) assault: Have there been any assaults which are a direct threat to life, or which have restricted breathing, such as strangulation, smothering, choking or drowning? Any grabbing around the throat should be considered a strangulation assault	Yes / No
Stalking: Is there any tracking, following, spying or watching, even within a relationship? Any covert entry to the victim's home?	Yes / No
Coercive control: Any attempts to control the daily activities or restrict the choices of the victim	Yes / No
Weapons: Any use of weapons or threats with weapons? Any posing with weapons in photographs?	Yes / No
Breach of Court Orders or Bail: Does the person breach court orders or bail conditions, even if those breaches don't seem serious?	Yes / No
Sexual aggression: Does the victim have sex or sexual contact when they really don't want to? Are they coerced in to sexual contact with others? Is there any rape?	Yes / No
Excessive jealousy: Does the person constantly accuse the victim of having affairs?	Yes / No
Child access arguments: Are there nasty child access arguments? Is winning the argument more important to the perpetrator than the happiness or welfare of the child?	Yes / No
Violence: Violence is always a risk marker. Is any violence increasing in its seriousness, frequency or menace?	Yes / No
Isolation of the victim?: Has the victim become isolated from family and friends?	Yes / No
Pregnancy: Abuse and violence often escalates in pregnancy. Women become more vulnerable when pregnant.	Yes / No

Threats to pets, friends and family: Have there been threats to harm the victim's family or friends? Have there been threats to harm pets, kill them, have them euthanized or abandon them?	Yes / No
Acting on threats: Has the person acted on any threats they have made?	Yes / No
Breaking in to the victim's home: Has the person gained entry to the victim's home, or attempted to, when they weren't there?	Yes / No

Area 3: Threat triggers

Are any factors in the checklist below present? Yes / No	
If "Yes": please give details:	
Separation: Has there been a separation? Is one planned? Does the perpetrator imagine there is one planned?	Yes / No
Financial ruin / difficulties: Has there been a bankruptcy, retirement, or redundancy for example? An event which threatens the perpetrator's financial control and stability?	Yes / No
Deteriorating health: This can be mental or physical health, and can the health of the victim or the perpetrator	Yes / No
Major life changing events: For example, redundancy or retirement. These life changes can trigger anxiety about too much change. Too much change can mean diminishing control	Yes / No
Any event which challenges control or entitlement: Many things can threaten control. You may need to use professional curiosity to find out if anything is going on	Yes / No
Revenge or retaliation: The stalker or perpetrator may consider the victim has betrayed them in some way and needs to be punished	Yes / No
Humiliation: Has anything happened to challenge the person's perceived sense of status? This could be financial ruin, separation, or losing a job for example	Yes / No

Assessing the level of risk

In how many areas of the triad are there concerns?

0	
1	Consider taking some positive action as domestic abuse always gets worse
2	The situation is serious and positive action should be taken
3	Take positive action urgently as this is a serious situation

Actions to consider taking include:

- Refer to your organisational domestic abuse / stalking policy
- Record your concerns
- Consider safety and take specialist advice
- Let the person know of any help / helplines
- Use professional curiosity
- Find out when and how it is safe to contact the person

14 Appendix C: The use of the Mental Capacity Act 2005 in complex cases

The Appendix captures the learning from a Serious Case Review carried out by Lambeth Safeguarding Adult Board.

Serious Case Review for Miss B
Miss B was a person that Lambeth Adult Social Care and a number of local health services worked with in the years before her death in 2010. She had complex needs associated with physical and learning disabilities. There were a number of concerns about the circumstances leading up to her death, including how well she was supported by social care and health services, so the was a safeguarding adults investigation and a Serious Case Review.

The Serious Case Review identified that the work with Miss B had not applied the Mental Capacity Act 2005 (MCA) properly. One of the reasons for this was the MCA is predicated on there being a single, clearly defined issue on the table when in fact, in Ms B's case, there were multiple small decisions that affected her welfare cumulatively. This will be a common feature of situations involving people with complex needs.

Another issue in Miss B's case was that there were concerns from time-to-time from some health and social care professionals that her family may not always have ensured she received the health care that she needed. The family sought out medical input at some times but at others they seemed unable to cooperate with her medical care. They were of the belief that medical intervention had been the cause of their daughter's impairments.

This was emotionally persuasive, but it did not represent sufficient grounds for avoiding orthodox medical treatments later in her life. The parents of a person without capacity can only remain in charge of decision-making as long as they are acting in the person's best interests; they do not have the right to deprive a person who lacks capacity of appropriate professional attention. So the views of Miss B's family in relation to her medical care should not have been allowed to act as a barrier to coherent planning and action or to deter the working of a properly managed professional network.

Had it been made clear to Miss B's parents that professionals have a legal duty to act in a vulnerable person's best interests and that these matters might have had to be resolved by making an application to the Court of Protection if a course of action could not be agreed upon, they might perhaps have been brought to the table to become part of a consensus-building process. There seems to have been insufficient explanation of the options, the benefits and downsides of them, or of the optimal timeframe for considering the interventions available. It is unclear why this was not formally on the table as a decision to be taken within the MCA framework despite Miss B's continued low BMI and on-going concerns about her nutritional status.

Perhaps Miss B's family would have counselled against further medical intervention .If so, their decision should have been made in an appropriately formal context within which Miss B's interests and human rights could have been represented and protected. It might be that

the Courts would have upheld such a decision. We cannot know what the outcome might have been, but this was clearly not a decision that should ever have been made behind closed doors.

Decision making and intervention in complex cases

Professionals, acting as decision-makers in respect of their particular remits, must intervene if they have concerns that a family member or another professional or organisation is not acting in the best interests of an adult who lacks capacity. This is not to say that cutting across a family's views, in this case to assess Miss B's best-interests, could ever have been other than painfully difficult. Moreover it was right that professionals were mindful of the care Miss B's immediate family provided and respected her place at the heart of their family life. But there are times when these matters should be challenged, first informally and then formally. These are decisions laden with anguish but they are nonetheless decisions that should have been made in a shared and open forum, guided by the person's best interests and scrutinised by an appropriate professional network.

This process, whereby a professional network has to switch from supporting family carers into a position where they are challenging their actions is extremely difficult to negotiate. Often decisions are delayed or fudged or unsuitable decisions that are not in a person's best interests keep on being made just under the radar of the MCA leading to inaction and paralysis in the professional network. Decisions may not be clearly "on the table" or their timing managed appropriately.

The MCA introduced a framework for decision-making in the best interests of adults who lack capacity to make some or all decisions by themselves. Although the Court of Protection has powers to appoint a "deputy" to act for a person unable to make significant decisions in several domains, a general authority to act was enshrined within this legislation allowing those closest to the person, such as a family member or carer, to make decisions on their behalf. The principle that has to be followed by anyone making decisions for someone who lacks capacity is that the decision is in their best interests.

Single issues about discrete medical treatment or social care decisions are covered thoroughly in the guidance to the MCA but managing complex decision-making, across all arenas of a person's life, or over time in relation to chronic health conditions, is less clearly anticipated.

Recent research has highlighted the difficulty of getting to grips with a series of relatively small decisions, rather than one single serious decision, even where the cumulative effect of those decisions might prove, as in this case, to be grave. Resistance, or hostility, from the carers in these studies made decision-making even more difficult. Lack of a clear consensus between health care professionals and failures in multi-agency communication were also mentioned as complicating factors. Daunting decisions or confrontations were often shelved until the optimal time for action had passed.

A framework for decision making

A framework that describes the distinct phases involved in shared decision-making and structuring the timing of practice interventions, decision making and if necessary the seeking of a legal mandate can be useful in such complex cases. Escalating concerns need to be placed within a clear managerial framework and a process of graduated decision making should be followed as part of a commitment to enhanced care planning and risk management.

By using this framework, family members can be helped to understand that they have to work within the limits of what is in their relative's best interests as defined in standard clinical pathways and agreed practice. It also supports the professionals involved to meet the expectations on them to

- Support involvement in the decision making by the person as far as is reasonable possible

- Ensure that those with an interest in the person's welfare, including family and friends, are given all the relevant information and any differences in view are explored and understood and attempts are made to resolve them

The table below sets out the phases of such an approach

A phased approach	Tasks to prevents harm and contain risk
Support	Provide encouragement and access to any necessary resources
Inform	Inform person of minimum standard of care and/or of agreed best practice
Challenge	Challenge where these standards are not being met
Adapt	Negotiate around difficult areas or short cuts
Agree	Agree any reasonable compromises
Insist	Be clear that you expect these standards to be adhered to, eg insist on attendance at appointments and follow up on any slippage
Intervene	Take action under MCA or MH or within regulatory framework

Putting the phased approach in to practice

Effective use of the phased approach is dependent upon

- Identification in a timely way of situations where the issues around complexity and mental capacity are relevant
- Cases being properly assigned, coordinated and risk-managed, with clarity about leadership of this
- Health and social care services working together
- Health care being proactively planned using proper evidence based treatment pathways.
- Acknowledging and negotiating differences of opinion, understanding and knowledge between family carers and the health professionals
- Ensuring the respective roles and responsibilities of family members and health care professionals are clear to everyone

- Ensuring there is clarity about the responsibility of health and social care professionals to intervene in family care where this is manifestly not in the person's best interests

In adult social care, typical ways to achieve this are

- In the context of an assessment of needs for care and support. The person undertaking the assessment would be in the leadership role.
- In the context of assessment of capacity and best interests decision making under the Mental Capacity Act 2005. The person in the role of decision-maker would be in the leadership role.
- In the context of a safeguarding adults enquiry. The person in the role of Safeguarding Adults Manager would be in the leadership role

References

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