



# Safeguarding Vulnerable Adults

Regional Adult Protection Policy & Procedural Guidance

SEPTEMBER 2006

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## Foreword

The abuse and exploitation of vulnerable adults is an issue that has become more prominent in recent years in terms of public awareness. It has also been increasingly reflected in the priorities of a wide range of organisations through the development of more effective responses and a great deal of progress has been made, as a result of local initiatives. This has resulted in a number of policies and procedures which are broadly similar but which do not allow for the degree of commonality and standardisation needed to underpin effective inter-agency endeavours in this complex area of work.

In 2002 the Department of Health, Social Services and Public Safety (the Department) supported the establishment of the Regional Adult Protection Forum to promote, develop and improve arrangements for the protection of vulnerable adults. It has become increasingly clear that a major contribution to effecting further significant progress lies in the production of regional policy and procedures. The need to address this issue has been brought into even sharper focus, and has been reinforced, by the degree of organisational change proposed by the Review of Public Administration.

In 2005 the Forum received Departmental endorsement to produce standardised, regional procedures. 'Safeguarding Vulnerable Adults', which is based on best practice, represents the outcome of that work and has been subject to widespread consultation. Whilst it marks a major step in improving

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adult protection arrangements it has been produced at a time when further change is anticipated in areas such as legislation, governance and models of service delivery. Comparison with equivalent processes in child protection help to illustrate the potential for further amplification and development. It is for these reasons that the Department is committed to reviewing the procedures when the initial phase of the organisational change referred to above has been completed. The Regional Forum will be asked to monitor and oversee this process.

The production of this document represents a major new phase in improving adult protection arrangements across the region. We do not underestimate the commitment that will be required to promote the effective operation of these procedures across the range of relevant organisations, but the Department is committed to ensuring that this happens. We would therefore commend the policy and procedures outlined in 'Safeguarding Vulnerable Adults' and expect it to be used as a framework within which we can effect major changes in this important area of work.



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**Deputy Secretary**

**Department of Health, Social Services and Public Safety**

**September 2006**



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## 1.0 Policy - Introduction

- 1.1** Any adult at risk of abuse, exploitation or neglect should be able to access support to enable them to live a life free from violence and abuse. These procedures detail the processes that must be followed in the event of a suspicion or allegation that a vulnerable adult is at risk of abuse, exploitation or neglect. The procedures do not cover other responses to their needs. They are a vital part of a range of prevention, support and protection services offered to meet the needs of vulnerable adults, their families and carers.
- 1.2** The purpose of regional procedural guidance for Northern Ireland is to ensure a co-ordinated and standardised approach by all those who work with vulnerable adults and to establish the principles of good practice in this important area of work. This policy and the procedures which flow from it are derived from best practice in Northern Ireland and with reference to developments elsewhere in the UK.
- 1.3** The most recent guidance from the Department of Health has identified the need to establish a framework for action to ensure that there is:
- ‘a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agencies’ primary aim should be to prevent abuse where possible but, if the preventive strategy fails, agencies should ensure that robust procedures are in place for dealing with incidents of abuse ’<sup>1</sup>.*
- 1.4** The following statements underpin the implementation of activities related to the protection and safeguarding of vulnerable adults:
- agencies and organisations will work co-operatively in the identification, investigation, treatment and prevention of abuse of vulnerable adults;

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- a consistent response will be made to vulnerable adults when concerns are raised whether these are reported through complaints procedures, inspection or registration activity, as a result of whistle-blowing or as a result of disclosure on the part of vulnerable adults or their carers;
  - action will be co-ordinated against alleged perpetrators to ensure that parallel processes are dovetailed including prosecution, disciplinary action and removal from, or notification to, professional registers and similar bodies;
  - there is a responsibility to share information on a “need to know” basis so that effective decisions can be made and appropriate preventative action taken.

A co-ordinated approach in Northern Ireland will require the adoption and implementation of agreed regional procedures by Boards and Trusts. Such a process will need to include the strengthening of relationships with all providers of services and compatibility with the statutory responsibilities of other agencies and to policies already in force within them, in particular the Police Service of Northern Ireland (PSNI) and the Regulation and Quality Improvement Authority (RQIA).



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## 2.0 Scope

- 2.1** This guidance is for all staff, regardless of employing organisation and sector, who provide health or personal social services to vulnerable adults in any setting or context. It is applicable to the protection from abuse of vulnerable people aged 18 or over and includes older people, people with a learning, physical or sensory disability and people with mental illness or dementia. It covers all types of abuse, including neglect and recognises that vulnerable people cannot always protect themselves.
- 2.2** The procedures within this guidance do not operate independently of other arrangements (see paragraph 1.4), such as complaints and disciplinary procedures, and should be implemented concurrently in order to ensure the protection of the vulnerable adult.

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## 3.0 Definitions

### Definition of Vulnerable Adult

- 3.1** The existing definition of ‘vulnerable adult’ varies across Boards and Trusts. It is important that there is a single, agreed definition of this term. The Regional Adult Protection Forum has adopted the Law Commission for England and Wales (1995) definition of a “vulnerable adult” as:

*‘a person aged 18 years or over who is, or may be, in need of community care services **or** is resident in a continuing care facility by reason of mental or other disability, age or illness **or** who is, or may be, unable to take care of him or herself **or** unable to protect him or herself against significant harm or exploitation’<sup>2</sup>.*

Adults who “may be eligible for community care services” are those whose independence and wellbeing would be at risk if they did not receive appropriate health and social care support. They include adults with physical, sensory and mental impairments and learning disabilities, howsoever those impairments have arisen; eg whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

### Definition of Abuse

- 3.2** The current definition of abuse is derived from regional guidance issued by the Management Executive, Department of Health and Social Services, in 1996, which states that abuse is:

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*'The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship'<sup>3</sup>.*

**3.3** Forms of abuse can be categorised as follows:

- physical abuse (including inappropriate restraint or use of medication);
- sexual abuse;
- psychological abuse;
- financial or material abuse;
- neglect and acts of omission;
- institutional abuse; and
- discriminatory abuse.

**3.4** Incidents of abuse may be multiple, either to one person in a continuing relationship or service context, or to more than one person at a time.

**3.5** Any or all types of abuse may be perpetrated as the result of deliberate intent and targeting of vulnerable people, negligence or ignorance.

### **Significant Harm**

**3.6** The Law Commission in its 1995 report<sup>2</sup> makes use of the concept of significant harm as an important threshold when considering the nature of intervention and defines this as including not only ill-treatment

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(including sexual abuse and forms of ill-treatment which are not physical), but also the impairment of physical, intellectual, emotional, social or behavioural development. Significant harm may include the degree, extent, duration and frequency of harm.

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## 4.0 Guiding Principles

**4.1** A set of commonly agreed principles underpins this regional procedural guidance. Such principles flow from respect for the rights of vulnerable adults who are entitled to:

- privacy;
- be treated with respect and dignity;
- lead an independent life and be enabled to do so;
- be able to choose how to lead their lives;
- the protection of the law;
- have their rights upheld regardless of ethnic origin, gender, sexuality, impairment or disability, age and religious or cultural background; and
- have the opportunity to fulfil personal aspirations and realise potential in all aspects of daily life.

This includes Human Rights considerations, particularly in relation to Article 2 “the Right to Life”, Article 3 “Freedom from Torture” (including humiliating and degrading treatment), and Article 8 “Right to Family Life” (one that sustains the individual).

Human Rights must be considered in all decision making processes, and due consideration given to concepts of proportionality and equality of arms.

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## 5.0 Individual Rights

**5.1** These principles assume that vulnerable adults have the right to:

- be accorded the same respect and dignity as any other adult, by recognising their uniqueness and personal needs;
- be given access to knowledge and information which they can understand to help them make informed choices;
- information about, and practical help in, keeping themselves safe and protecting themselves from abuse;
- live safely, without fear of violence or abuse in any form;
- have their money, goods and possessions treated with respect, and to receive equal protection for themselves and their property through the law;
- guidance and assistance in seeking help as a consequence of abuse;
- be supported in making their own decisions about how they wish to proceed in the event of abuse and to know that their wishes will only be over-riden if it is considered necessary for their own safety or the safety of others;
- be supported in bringing a complaint under any existing complaints procedure;
- be supported in reporting the circumstances of any abuse to independent bodies;
- have alleged, suspected or confirmed cases of abuse investigated urgently;
- receive appropriate support, education, counselling, therapy and treatment following abuse;
- seek legal advice or representation on their own behalf;
- seek redress through appropriate agencies;
- have their rights respected and to have their family, informal carers or advocates act on their behalf as appropriate.

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## 6.0 Inter-Agency Working

**6.1** The principles and rights that have been identified can be further strengthened through the promotion of effective inter-agency co-operation, training and multi-disciplinary working. The operating principles which are needed to make this happen have already been specified as part of the recent work between HPSS and PSNI staff in developing procedures to improve co-operation in the field of adult protection<sup>4</sup>.

**6.2** These include the requirements for agencies to:

- actively work together within an identifiable inter-agency procedural framework encompassing effective communication, an appropriate risk management framework and clarity about agency and professional responsibility, authority and accountability;
- actively promote the empowerment and wellbeing of vulnerable adults through the services they provide;
- ensure the safety of vulnerable adults by integrating strategies, policies and services relevant to abuse within existing procedural frameworks;
- act in a way which supports the rights of the individual to lead an independent life based on self-determination and personal choice;
- ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help, including advice, protection and support from relevant agencies;
- recognise that the right to self-determination can involve risk and ensure that such risk is recognised and understood by all concerned and minimised whenever possible; and
- ensure that the law and statutory requirements are known and used appropriately so that vulnerable adults receive the protection of the law and access to the judicial process.

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## 7.0 Confidentiality

- 7.1** In normal circumstances observing the principle of confidentiality will mean that information is only passed on to others with the consent of the service user. However it should be recognised that in order to protect vulnerable adults, it may be necessary, in some circumstances, to share information that might normally be regarded as confidential.
- 7.2** All vulnerable adults and, where appropriate, their carers or representatives need to be made aware that the operation of multi-disciplinary and inter-agency procedures will, on occasion, require the sharing of information in order to protect a vulnerable adult or others, or to investigate an alleged or suspected criminal offence.



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## 8.0 Consent and Capacity

**8.1** One of the key challenges in relation to work with vulnerable adults relates to capacity and consent in considering what action should be taken about alleged or suspected abuse. Two key questions need to be addressed:

- (i) did the vulnerable adult give meaningful consent to the act, relationship or situation which constitutes the alleged or suspected abuse?
- (ii) does the person now give meaningful consent to any preventable action, investigation or report to the PSNI?

**8.2** It is also necessary to determine both whether the person could consent and whether they did consent. Abuse may occur when any of the following conditions apply:

- the person does not consent;
- the person is unable to consent, either because of issues of capacity or because the law does not permit the vulnerable adult to give consent to a particular act or relationship;
- other barriers to consent exist for the vulnerable adult; eg where the person may be experiencing intimidation or coercion.

**8.3** The principles contained in Good Practice in Consent (DHSSPS, 2003)<sup>5</sup> and enshrined in the legislation relating to mental incapacity which have been enacted in England and Wales<sup>6</sup>, offer some useful guidelines for determining individual capacity and ability to consent. These include:

- a person must be assumed to have capacity unless it is clearly established that this is not so;
- a person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success;

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- a person should not be considered as being unable to make a decision merely because he makes an unwise decision;
  - an act done or decision made under this legislation for, or on behalf of, the person who lacks capacity, must be done, or made, in his best interests;
  - before any action is taken, or decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

**8.4** Under this legislation a person is deemed to lack capacity in a matter if, at the same time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary. A person is deemed unable to make a decision for himself if he cannot:

- understand the information relevant to the decision;
- retain that information;
- use or weigh-up that information as part of the process of making that decision;
- communicate his decision (by speech, gesture, signing or any other means).

**8.5** Where a person is deemed unable to make a decision every reasonable and practicable effort must be made to encourage and permit the person to participate, or to improve his ability to do so as fully as possible in any act done for him and decision affecting him. If it is decided that an adult does not have capacity, then staff should act in a way which is in that person's best interests; ie what is necessary to promote health or wellbeing or prevent deterioration, consistent with existing legislation.



## PART II PROCEDURES

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## 9.0 Introduction

- 9.1** This part of the document outlines the core elements of adult protection procedures. It is important that they identify the responsibilities of different groups of staff, including reporting mechanisms.
- 9.2** The process of dealing with an allegation or suspicion of abuse of a vulnerable adult goes through a number of distinct stages. The following have been identified:
- alerting;
  - referring;
  - screening;
  - planning the investigation;
  - investigating;
  - making decisions;
  - monitoring and review.
- 9.3** Each stage is examined in turn and the roles and responsibilities of staff described. It will not be necessary to follow through all of these stages in every case. A decision may be reached at any stage to resolve the issue by providing care management or other services. At the other end of the spectrum, it may be necessary to reconvene a strategy meeting if new evidence comes to light which moves the focus of the investigation beyond its initial remit.
- 9.4** The protection of vulnerable adults from abuse should always receive high priority from all agencies involved. Concerns about abuse should be reported immediately.

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## 10.0 Alerting

- 10.1** Alerting refers to the responsibility to recognise abusive situations and inform a nominated manager within the agency. It plays a major role in ensuring the protection of vulnerable adults and it is important that all concerns about possible abuse, however trivial, should be reported. An alert may come from any person who has knowledge or a reasonable suspicion that a vulnerable adult has been, or is at risk of, being abused.
- 10.2** Everyone working with vulnerable adults has a duty to report suspected, alleged or confirmed incidents of abuse. In a situation where a staff member has concerns, they should report this immediately to their line manager or to a senior manager if consultation with their line manager would involve undue delay.
- 10.3** If the allegations relate to another employee, the staff member should alert their line manager. If the allegations relate to the line manager, the staff member should report the matter to a more senior manager. It should be noted that the Public Interest Disclosure (Northern Ireland) Order 1998 provides for the active safeguarding and protection of what are commonly known as 'whistle blowers'.
- 10.4** If the person who suspects abuse is employed within the voluntary, private or independent sector, they should report their concerns to their line manager whose responsibility it will be to refer to the appropriate Health and Social Services Trust Officer or Designated Officer.

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- 10.5** Concerns about suspected abuse by staff should also be reported to the RQIA as outlined in the appropriate regulations. Staff providing assistance to the vulnerable adult at this stage will need to obtain as much information as possible pertaining to the allegation or suspicion of abuse, particularly if a criminal offence has been committed. Staff should only clarify the basic facts of the suspected abuse or grounds for suspicion. They should avoid asking leading questions and should not discuss the allegation with the victim or the alleged perpetrator. Staff should be clear that their role is primarily supportive rather than investigative.
- 10.6** Members of the public wishing to remain anonymous, or persons providing information who do not wish to be identified, should be aware that, while anonymity will be honoured as far as possible, it cannot be unconditionally guaranteed. They should be made aware that they may be required to give evidence, or their name may have to be disclosed in Court.
- 10.7** On receiving an alert of an allegation or suspicion of abuse, the line manager should check that the vulnerable adult's immediate needs are being met; ie that they are in no immediate danger and that medical assistance, if deemed necessary, has been sought.

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## 11.0 Referral

- 11.1** All referrals should be made to the appropriate Designated Officer. This contact may be made by telephone in the first instance, but should be confirmed in writing within 2 working days. The Designated Officer should then acknowledge receipt of the referral within 2 working days.
- 11.2** When deciding the level of urgency of any referral, the degree of apparent risk should be the deciding factor. Some cases of abuse will require a rapid response and service provision must allow for this.
- 11.3** The first priority should always be to ensure the immediate safety and protection of the vulnerable adult. This may involve calling the relevant emergency service or considering, with the vulnerable adult, if they can move to a place where they feel safe. Life threatening situations, such as severe physical abuse, require an immediate response. In all other circumstances, allegations of abuse should be the subject of an initial investigation within 3 working days.
- 11.4** Situations arising outside of normal office hours and requiring immediate intervention should be passed on to the appropriate Out of Hours Social Work Service. The Duty Social Worker should give priority to the protection of the vulnerable person and report to the appropriate Designated Officer at the earliest opportunity when offices re-open.

### **Allegations against staff and paid carers**

- 11.5** Disciplinary investigations of allegations against staff and paid carers will be undertaken within the disciplinary procedures of the employing agency. They should be conducted separately from any enquiry or investigation under Protection of Vulnerable Adult Policies and Procedures, although there may be a need for simultaneous action

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and for the co-ordination and sharing of information. Where a criminal investigation is taking place, the disciplinary procedure may not be able to be concluded until this has been completed.

- 11.6** Employers should ensure that their disciplinary procedures are compatible with the responsibility to protect vulnerable adults. Where appropriate, they should report workers to the relevant statutory and other bodies responsible for professional regulation; eg Northern Ireland Social Care Council, Nursing and Midwifery Council, General Medical Council, Protection of Vulnerable Adults' lists.



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## 12.0 Screening

**12.1** Decisions around the threshold for intervention are questions of judgement.

The Designated Officer, along with fellow professionals and relevant others must:

- establish the substance of the suspected, alleged or known abuse;
- establish that the individual falls within the scope of the policy.

**12.2** It is also important that the person's Human Rights are considered. Unnecessary or premature initiation of a vulnerable adult investigation should be avoided.

**12.3** In deciding whether further investigation is necessary, the following factors need to be considered:

- the vulnerability of the individual;
- the nature and extent of the abuse;
- the length of time it has been occurring;
- the impact on the individual;
- the risk of repeated or increasingly serious acts involving this or other vulnerable adults.

### Consent and Capacity

**12.4** It is important to consider issues of consent and capacity in order to establish the individual's ability to give meaningful consent to the abusive act or situation or to any further investigative process. The guiding principles in relation to these issues are outlined in Section 8 of this document.

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## Dispensing with Consent

**12.5** When considering the vulnerable adult's ability to give meaningful consent, there should be full discussion and reference to legal and medical advice before any decision is made. In the context of adult protection, there will be some circumstances in which it will be necessary to over-ride the wishes of the individual even though they are deemed to be capable of giving meaningful consent. These will include situations:

- where there is an over-riding public interest; eg to prevent serious harm or injury to others; or
- where there is a requirement to investigate a criminal offence.

**12.6** In all cases where the wishes of the individual are over-ridden, this should be fully explained both to them and their carer or advocate, where appropriate, and recorded in the service user's record.

## Outcomes of Screening

**12.7** Possible outcomes of initial screening may be that:

- no further action is required;
- referral for an appropriate assessment is made; eg for new or increased services; or
- further investigation under the Adult Protection Procedures is required.

## Where there is a decision not to proceed

**12.8** In all instances where an investigation is not pursued, the reasons for this decision, the personnel involved and any contrary advice should be noted. The file note should be countersigned by the line manager and Designated Officer and forwarded to the appropriate senior manager.

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**12.9** The decision not to proceed under the Adult Protection Procedures does not necessarily mean that there are no issues about the adult's welfare. These may be addressed by other types of intervention; eg referral for an assessment of the individual and/or their carer. It is important to record details of any intervention provided or offered on the service user's record.

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## 13.0 Planning the Investigation

### Identifying Roles

- 13.1** The appropriate agency to lead the investigation will be the HSS Trust. Where another possible lead agency, such as the PSNI, is involved the host Trust should take a lead in ensuring that a strategy discussion take place and in co-ordinating the arrangements for this.

The PSNI has a legal duty to investigate alleged criminal abuse. Where there is a possibility of a criminal prosecution, the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults<sup>4</sup> **must** be followed.

On receipt of a referral, the Designated Officer will convene a strategy discussion and will appoint an Investigating Officer.

### Strategy Discussion

- 13.2** The purpose of the Strategy Discussion is to ensure an early exchange of information, to clarify what immediate action needs to be taken by whom and to determine the method of investigation. This should take place within one working day of referral to the Designated Officer unless good practice dictates otherwise. In most instances it will be appropriate for the Strategy Discussion to take place by telephone but, in a particularly complex referral, the telephone discussion may be extended to a meeting.
- 13.3** All relevant professionals and agencies should be involved in the discussion. The Regulation and Quality Improvement Authority (RQIA) must be notified in all situations where concerns have arisen in any registered establishment or agency as per the regulation. At this stage, in the case of allegations against staff members, consideration also has to be given to involving the relevant Human Resources Department.

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**13.4** The strategy for investigation should always be informed by information gained by those who have knowledge of the person and his or her circumstances. This may not be possible in a minority of cases; eg some referrals may require immediate action by the Trust or PSNI to ensure the protection of the person or the apprehension of a suspect.

#### **Outcome of Strategy Discussion**

- 13.5** The Strategy Discussion will make decisions on the following:
- the need for immediate protection;
  - whether to proceed under the Adult Protection Procedures;
  - the method of investigation; ie single or joint agency;
  - who will co-ordinate the investigation and conduct any interviews;
  - whom to interview;
  - the roles and responsibilities of those involved;
  - the need for protection of others viewed at risk;
  - the need for medical/psychiatric/psychological assessment;
  - what arrangements will be made for a person with a disability or special needs including the requirement for an interpreting service;
  - what support the vulnerable adult, informal carers and family members will be offered during the investigation, as well as the alleged perpetrator if they are a vulnerable adult or service user;
  - the wishes, if known, of the vulnerable adult involved;
  - the rights of those involved in the investigation;

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- the need to report to other bodies, such as RQIA, Mental Health Commission, Professional Bodies;
  - arrangements for reporting back to the Designated Officer;
  - a communication strategy/press statement (if appropriate).

**13.6** A record of the Strategy Discussion must be completed by the Designated Officer or Chair of the Strategy Discussion Meeting.

#### **Methods of Investigation**

**13.7** Depending on the decisions of the Strategy Discussion, the investigation may proceed through single agency investigations, joint investigations or joint investigations with the PSNI.

**(a) Single Agency Investigations**

These are investigations where intervention rests solely with one agency; eg Trust, PSNI.

**(b) Joint Investigations**

These are investigations which involve more than one agency or organisation but which lie outside the 'Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' (eg Joint Investigations between Trust, RQIA, voluntary organisations, etc).

**(c) Joint Investigations with the Police**

A detailed consideration of the need for a joint investigation with the PSNI will be triggered when there is an allegation or suspicion that one of the following criminal offences has been committed against a vulnerable adult:

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- a sexual offence committed against a vulnerable adult;
  - physical abuse or ill-treatment amounting to a criminal offence;
  - financial abuse involving a criminal offence such as fraud or theft; or
  - abuse which involves a criminal offence; eg blackmail.

- 13.8** The vulnerable adult should be advised of their right to report the alleged or confirmed abuse to the PSNI at an early stage.
- 13.9** In all cases of alleged or suspected criminal abuse, the Designated Officer should consult with the relevant Police Liaison Officer. It will be the responsibility of the Police Liaison Officer to help determine whether the matter may involve criminal abuse and thereby inform the decision concerning what level of enquiry or investigation is necessary.
- 13.10** Alleged or suspected sexual abuse should be reported to the Detective Inspector - Child Abuse and Rape Enquiry (CARE) team who holds the role of Police Liaison Officer for sexual crimes.
- 13.11** Alleged or suspected non-sexual abuse should be reported to the Police District Command Unit (Crime Manager) who holds the role of Police Liaison Officer for non-sexual crimes.
- 13.12** Where more than one form of abuse is alleged or suspected, sexual offences will take precedence and these cases should be referred in the first instance to the Detective Inspector (CARE).
- 13.13** A referral to the PSNI does not automatically mean that a joint investigation will be initiated. In the majority of cases, the PSNI will only proceed with the consent of the vulnerable adult. In practice this means that the vulnerable adult should be willing to make a complaint to the PSNI. However there are some exceptions to this:

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- where the vulnerable adult is deemed not to have capacity;
  - where the vulnerable adult is subject to undue influence;
  - where others may be at risk;
  - to prevent a crime being committed;
  - where the vulnerable adult has been the victim of a serious crime or a serious crime may take place.

**13.14** Where a decision to proceed to joint investigation is taken, the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults **must** be followed.

**13.15** Where the vulnerable adult receives a service from a registered establishment or agency, the Designated Officer must refer the matter immediately to the appropriate Inspector within RQIA. Close liaison and co-operation in relation to this will be essential in order to ensure an effective outcome. This procedure applies to statutory, private and independent sector provision.

The Manager of the registered facility or service also has a responsibility to inform RQIA of any ongoing investigations.

**13.16** Where care is being purchased outside of the Board/Trust area, the Designated Officer of the host Trust should liaise with the Trust who has made the placement to satisfy themselves, of the individual's ongoing protection. They should also ensure that the allegation has been notified to the relevant Inspector within RQIA.

### **Accident and Emergency and Hospital In-Patients**

**13.17** When a vulnerable adult presents at an Accident and Emergency Unit or is a patient in a hospital facility and there is a concern or allegation of abuse, the hospital staff have a duty to alert their line manager. The



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line manager should refer to the Designated Officer for the hospital who will, in turn, liaise with the appropriate Designated Officer in the community to determine who will take the lead role in the investigation.

- 13.18** It is essential that all professionals involved liaise effectively and that a Care and Protection Plan is in place before the patient is discharged. The Designated Officer for the hospital should inform the appropriate senior manager within Clinical Services and the RQIA of any investigation that takes place and its outcome.
- 13.19** Where the concern or allegation relates to a vulnerable adult who is known to Mental Health services or the Learning Disability Programme of Care, the Designated Officer for the hospital should inform the Mental Health Commission when an investigation is initiated and also of the eventual outcome.

#### Individuals who are in receipt of Direct Payments

- 13.20** People who are purchasing their own services through the Direct Payments scheme and their relatives should be made aware of the arrangements for the management of adult protection in their area. Such service users should receive the same level of support and protection as any other vulnerable adult if abuse occurs.

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## 14.0 Investigating

- 14.1** The investigation strategy should be implemented as agreed at the Strategy Discussion. The Investigating Officer will take the lead role in undertaking the investigation and in keeping the Designated Officer informed. This role will require an experienced and suitably trained professional who will be responsible for direct contact with service users, informal carers or relatives involved in the case. In many instances, it will be appropriate to involve other staff in the investigation in order to ensure that an appropriate assessment is made.
- 14.2** The involvement of the vulnerable adult and significant others should be a primary consideration during the investigation.
- 14.3** The purpose of the investigation is to:
- establish the facts about the circumstances giving rise to the concern about the abuse or neglect;
  - decide if there are grounds for concern;
  - identify the sources and levels of risk;
  - determine who is responsible and recommend what action or support may be necessary in relation to them;
  - decide protective or other actions in relation to the persons concerned or any other vulnerable adult.
- 14.4** The Investigating Officer should ensure that the alleged victim is interviewed, if appropriate. The process of investigation may take several interviews. The needs of the vulnerable adult, informal carer or carers and, where appropriate, the alleged abuser should be considered. Investigations need to be handled with the utmost sensitivity, recognising that both parties may have a continuing relationship into the future. Where the individual makes a direct

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disclosure of abuse, they should **NOT** be interviewed in the presence of the alleged perpetrator unless in exceptional circumstances.

- 14.5** The vulnerable adult may wish to have someone else present during the interview - a carer, friend, independent advocate or another member of staff. This should be facilitated where possible. There may also be the need to have an interpreter present where communication difficulties arise.
- 14.6** In instances of abuse that constitute a criminal offence and there is a decision that Social Services and PSNI will jointly interview the vulnerable adult this can **only** be undertaken by an interviewer who has been trained in the procedures specified in Achieving Best Evidence <sup>7</sup>. It will be the responsibility of each agency to ensure that the interview and investigation process is properly supervised and supported by relevant managers who have been trained in these procedures.
- 14.7** The Investigating Officer should keep the Designated Officer fully informed of developments throughout the investigation process.
- 14.8** When interviewing alleged perpetrators, agencies and staff should remain mindful of the potential for violence and aggression. They should adhere to agency risk management/health and safety policies to ensure staff are adequately protected in such circumstances.
- 14.9** If there are no significant indicators of risk or insufficient evidence to substantiate concern, a written record should be made by the Designated Officer which clearly sets out the reasons for taking a decision not to proceed to formal Case Discussion. Consideration should be given to whether:
- the vulnerable adult or significant others require counselling regarding the investigation;

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- the person or others; eg their carers should be assessed for services;
  - a multi-disciplinary care planning meeting should be convened.

### **Actions if there are indicators of continuing risk**

#### **14.10** When one of the following occurs:

- the abuse is confirmed;
- there is substantial risk of abuse;
- there are suspicions of abuse and doubt remains;
- the vulnerable adult refuses help;
- action is going to be required by more than one agency;

a Case Discussion should be convened and chaired by the Designated Officer as soon as possible and no later than 14 working days after the completion of the investigation. The purpose of the meeting is to identify risks and the actions necessary to manage those risks.

#### **14.11** The Case Discussion may take the form of:

- (a) a formal Case Discussion; eg when the individual is deemed not to have capacity to consent; in situations where there may be more than one victim of the abuse or where a multi-agency response is required;
- (b) a Family Group Conference; eg where family relationship issues need to be addressed and family decisions are required;
- (c) a Risk Management Meeting; eg where the focus of discussion is on the risks and the actions needed to alleviate them, for example in the case of medication misuse.

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The Designated Officer will decide which meeting format is most appropriate and will both support the vulnerable person and secure commitment to any Care and Protection Plan.

Irrespective of which approach is adopted, the ongoing protection of the vulnerable adult must remain the key focus of the discussion.

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## 15.0 Making Decisions

**15.1** Regardless of the format adopted, the purpose of the Case Discussion is to consider the Investigating Officer's report and to formulate an agreed Care and Protection Plan for the individual. The tasks of the initial meeting are:

- to share and evaluate the information gathered in the investigation;
- to assess the level of risk to the vulnerable adult;
- to agree an inter-agency Care and Protection Plan;
- to appoint a key worker to oversee the implementation of the Care and Protection Plan;
- to identify any therapeutic interventions and follow-up work for the person who has been abused;
- where appropriate, to establish a Care Plan to work with the perpetrator if he or she is also a person who is vulnerable;
- to arrange appropriate follow-up support for carers if necessary;
- to agree a review date within 3 months;
- to inform RQIA of agreed action.

### Attendance at Meeting

**15.2** The circumstances will dictate who it is appropriate to invite to the meeting. All agencies and professionals who have been involved in the investigation or who may play a role in providing services to the vulnerable adult should be included as well as the vulnerable adult and their carer.

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However, it may not be appropriate for the vulnerable adult and alleged perpetrator to be involved in these meetings when a PSNI investigation is in process.

- 15.3** The vulnerable adult may choose to attend with an advocate or other representative. Alternatively they may choose for an advocate or other person to attend the meeting on their behalf.
- 15.4** If the carer is the suspected abuser, the vulnerable adult's views should be taken into account concerning the carer's attendance. If the vulnerable adult's ability to understand the procedure makes their attendance inappropriate, the Designated Officer should ensure that their views are represented. The sequence of events in the meeting needs to be considered and the vulnerable adult or their carer should not be present when disciplinary matters or action to be taken in regard to another service user are being discussed.
- 15.5** If the alleged perpetrator is also a vulnerable adult, their needs may have to be considered in a separate meeting.
- 15.6** The following is a checklist of those who may be required to be in attendance at the meeting:
- staff members who can assist in clarifying what is known about the actual or potential abuse;
  - professionals who have taken part in the adult protection investigation and any investigation in relation to other procedures and criminal matters, including the PSNI;
  - staff who can contribute to the formulation of a Care and Protection Plan (Social Workers, Care Managers, Community Nurses, Health Visitors, Allied Health Professionals such as Occupational Therapists, Residential and Day Care staff);
  - General Practitioner;

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- Consultant/Accident and Emergency Staff;
  - RQIA Representative;
  - Professionals who can offer specialist advice; eg Psychiatrists, Psychologists, Legal Representative, Social Security Agency, Northern Ireland Housing Executive;
  - the vulnerable adult and their carer, where appropriate;
  - an advocate for the vulnerable adult, where appropriate;
  - an interpreter for the vulnerable adult, where required.

**15.7** Once a long-term plan has been formulated, a small group of staff from the various disciplines and agencies involved should be identified as the core group who will work together to implement and review the Care and Protection Plan.

#### **Non Attendance at Case Discussion**

**15.8** Those who are invited to a formal Case Discussion meeting, but who are unable to attend, should ensure that their contribution is made through a written report to the Designated Officer. Particular attention should be paid to arranging the meeting so that those with a particular contribution and otherwise inflexible commitments can attend.



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## User and Carer Involvement

**15.9** In deciding the appropriate meeting format, consideration should be given to ensuring that the views of the vulnerable adult and carers are heard or represented in what may be a potentially intimidating situation for them. Participation can be encouraged in the following ways:

- meetings should be held at a time and place which is convenient for the vulnerable adult and their carer(s);
- the procedures involved should be explained;
- the vulnerable adult and their carer(s) should be given help in preparing their views on the issues identified;
- the vulnerable adult should have access to an independent advocacy service;
- meetings should be service oriented and use jargon-free language.

## Recording the Meeting

**15.10** The Designated Officer should arrange for an accurate minute of the proceedings to be made, which clearly identifies decisions made, by whom actions are to be taken, and the agreed timescales for action and review. Any dissent should be recorded and resolution agreed. The minute should be signed by the Designated Officer and copied to all participants.

**15.11** All agencies should identify arrangements, consistent with principles of fairness, for making records available to those affected by, and subject to investigation.

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## Agreeing the Care and Protection Plan

**15.12** A Care and Protection Plan should be drawn-up in consultation with the vulnerable adult that sets out:

- what steps are to be taken to ensure their safety in the future;
- what service, treatment or therapy they can access;
- modifications in the way services are provided to them;
- how best to support them through any action they take to seek justice or redress;
- any ongoing risk management strategy, where this is deemed appropriate; and
- who is responsible for the implementation and ongoing management of the Care and Protection Plan. This may be the service user's key worker, the Investigating Officer, or other nominated person.

**15.13** The Designated Officer must ensure that the Care and Protection Plan is circulated to all relevant parties, including the vulnerable adult and their carer, if appropriate, within 3 working days.

**15.14** The Care and Protection Plan may also address the need to work with the perpetrator of the abuse. Where the perpetrator poses a risk to others, the Designated Officer should share this information with relevant others. (see Section 7).

**15.15** Particular attention is needed in planning care which may be required in the future; for example, a vulnerable adult may be safe while the person who abused them is being held in custody or prison but protection may need to be reinstated when that person is released.

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## 16.0 Monitoring and Review

- 16.1** Monitoring an individual case involves overseeing the services provided for the vulnerable adult to ensure that the individual's Care and Protection Plan is effective in protecting them from further abuse.
- 16.2** In situations where the vulnerable adult is considered to be still at risk, the case should be kept under review and further action taken within 24 hours or as considered necessary to safeguard them.
- 16.3** The Care and Protection Plan will have identified the person responsible for monitoring its operation. This should be reviewed with service providers, the vulnerable adult and carers within 10 working days of its implementation. Any concerns that arise about the operation of the Care and Protection Plan should be reported to the Designated Officer. If the responsible person is ceasing to work with the vulnerable adult, they must inform the Designated Officer immediately so that a replacement can be arranged.
- 16.4** The Care and Protection Plan should be further reviewed at a minimum of 3 monthly intervals, or more often if necessary.
- 16.5** The decision to cease reviews should normally be made following a formal Case Discussion. However there may be circumstances in which it is obvious that the vulnerable adult is no longer exposed to any risk, such as no further contact with the abuser or moving to a more protective environment. The Designated Officer must inform all relevant parties of the decision to end the review process in writing, and to ask for their views.

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- 16.6** At the initial or review Case Discussion meeting, it may be decided that the case can be satisfactorily managed within existing line management arrangements. In these circumstances:
- the first meeting must take place within 6 weeks of the case conference;
  - the line manager and the responsible person will address the concerns identified at the Case Discussion meeting.
- 16.7** Where a case remains open for other forms of intervention, the date of closure of adult protection reviews should be clearly recorded. The file note should be countersigned by the line manager and the Designated Officer and forwarded to the appropriate senior manager.

#### **Monitoring for Statistical Purposes**

- 16.8** Periodic audits of individual adult protection case records will enable strengths and weaknesses in current practice to be identified.

Standardised recording and monitoring systems should be agreed across agencies to assist such information gathering.

- 16.9** Accurate and consistent monitoring of vulnerable adult data will increasingly enable agencies across the region to base their policy and practice on sound and relevant evidence, highlighting trends and assisting in the planning process.
- 16.10** RQIA may not be directly involved in the investigation but reserve the right to monitor and conduct an overview of the investigation carried out by a HSS Trust.



## PART III LEGAL FRAMEWORK

There is no specific legislation or body of common law relating to situations of risk or abuse of vulnerable adults. However there are pieces of legislation which seek to provide some protection and provide a potential framework for action. This list below is not finite:

- Criminal Law Amendment Act 1885;
- Offences Against the Person Act 1861;
- Marriages Act (Northern Ireland) 1954;
- Criminal Law Amendment Act (Northern Ireland) 1923;
- Public Health Act 1967;
- Health and Personal Social Services (Northern Ireland) Order 1972;
- Matrimonial Causes (Northern Ireland) Order 1978;
- Sexual Offences (Northern Ireland) Order 1978;
- Domestic Proceedings (Northern Ireland) Order 1980;
- County Courts (Northern Ireland) Order 1980;
- Mental Health (Northern Ireland) Order 1986;
- Marriage Act (Northern Ireland) 1983;
- Enduring Powers of Attorney (Northern Ireland) Order 1987;
- Prevention of Terrorism (Temporary Provisions) Act 1989;
- Police and Criminal Evidence (Northern Ireland) Order 1989;
- Northern Ireland (Emergency Provisions) Act 1996 and 1998;
- Homosexual Offences (Northern Ireland) Order 1982 as amended by Section 145(3) of the Criminal Justice and Public Order Act 1994;
- Human Rights Act 1998;

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- Criminal Evidence (Northern Ireland) Order 1999;
  - Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and Associated Regulations;
  - Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003;
  - Carers and Direct Payments Act (Northern Ireland) 2002.

Staff must interpret the rights, duties and powers available and apply them to individual circumstances. The following highlight some of these available to staff.

### **Human Rights**

The Human Rights Act 1998 is an Act of the Westminster Parliament which makes the European Convention on Human Rights part of the law of all parts of the United Kingdom. Although passed in 1998, the Human Rights Act did not fully come into effect until 2<sup>nd</sup> October 2000. In making the European Convention part of the law of Northern Ireland, the Human Rights Act allows individuals and organisations to go to Court, or to a tribunal to, seek a remedy if they believe that the rights conferred on them by the European Convention have been violated by a public authority (Section 7).

There are three main areas of law which provide a legal framework for the protection of vulnerable adults.

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## Criminal Law

Vulnerable adults are protected in the same way as any other person against criminal acts. If a person commits theft, rape or assault against a vulnerable adult they should be dealt with through the criminal justice system, in the same way as in cases involving any other victim. Where there is a reasonable suspicion that a criminal offence may have occurred, it is the responsibility of the Police to investigate and make a decision about any subsequent action. The Police should therefore always be consulted about criminal matters. Failure to disclose to the Police any information about a suspected criminal offence as defined in Article 26 of the Police and Criminal Evidence (Northern Ireland) Order 1989 is itself a crime.

Under the above Order provision is made for 'an appropriate adult' to protect the interests of the mentally ill or impaired individual while in Police detention.

The Criminal Evidence (Northern Ireland) Order 1999 makes provision for special measures, previously introduced for children when giving evidence, such as CCTV links and video recorded evidence-in-chief, to be extended to include vulnerable adults.

Indecent assault on a female is contrary to Section 52 and on a male is contrary to Section 62 of Offences Against the Person Act 1861. For an act to be considered an indecent assault there has to be actual or apprehended physical contact in 'circumstances of indecency' to which one or other party does not consent. This offence can be committed by either a man or a woman. Since a person with a severe

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learning disability cannot, in law, give consent, this means that any sexual contact between this person and someone who is not, may be construed as being indecent assault.

Article 3, Sexual Offences (Northern Ireland) Order 1978 states that a man commits rape if he has sexual intercourse with a woman whom he knows does not consent to it or where he is reckless as to whether she consents or not.

The Mental Health (Northern Ireland) Order 1986 gives power to an Approved Social Worker:

- (i) to make an application for assessment in respect of a mentally disordered person;
- (ii) to authorise admission to hospital of a mentally disordered person.

The assessment of risk is a critical element in the process of compulsory admission and all applications for assessment must be founded on the recommendation of a medical practitioner and made by an Approved Social Worker or nearest relative as defined by the Mental Health Order. In cases of dementia, it is the degree of impairment rather than the dementia itself which constitutes the mental disorder in terms of the legislation.

The purpose of Guardianship (Article 18) is primarily to ensure the welfare (rather than the medical treatment) of a person in a community setting where this cannot be achieved without the care of some or all of the powers vested in Guardianship. It provides a less restrictive means



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of offering assistance to a person who, either, has a mental illness or severe learning disability and should be considered as an alternative to detention in hospital.

To be received into Guardianship, a person must meet two criteria:

- (i) he or she must be suffering from 'mental illness or severe mental handicap'; and
- (ii) reception into Guardianship must be necessary in the interests of the welfare of the person.

The purpose of appointing a Guardian is to enable the '*establishment of an authoritative framework for working with the person with a minimum of constraint, to help them achieve as independent a life as possible within the community*'.

A Guardian has three essential powers:

- (i) to require the person to reside at a certain place;
- (ii) to require the person to attend for medical treatment, occupation, education or training at specific times and places; and
- (iii) to require access to be given at any place where the person is residing, to a doctor, Approved Social Worker or other person so specified by the Board.

Article 107 imposes a duty on employees of any Board, Trust, Nursing Home or home for persons in need to refer cases of adults deemed incapable of managing their affairs to the Office of Care and Protection, where no suitable arrangements are in place for the administration of their finance and business affairs. Even in cases where the estate may

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not be sizeable and where there are no suitable arrangements in place to deal with the estate, there is a statutory duty on the aforementioned to refer the case to the Office of Care and Protection. The responsibility is on the social worker to make adequate representation to the Court and to provide as much information as possible.

Article 121 states that it is an offence for a member of an administrative board or a staff member of a hospital or private nursing home to ill-treat or neglect a patient who is either receiving in-patient or out-patient treatment. Any individual who ill-treats or neglects a patient who is subject to Guardianship under this Order or who is otherwise owed a duty of care will also be guilty of an offence.

Article 122 offers protection to women who have a severe learning disability. It specifies that it is unlawful to have sexual intercourse with them, to encourage their prostitution, to supply premises for the purpose of sexual intercourse with them, or to take the person away from their carers in order to have sexual intercourse with them. Clinical assessment of their degree of disability is therefore very important when considering issues concerned with sexual activity either potential or actual and should be carried out by a clinical psychologist or psychiatrist specialising in the field of learning disability.

Article 123 makes it an offence for a man to have unlawful sexual intercourse with a woman suffering from any form of mental disorder if the man is a manager or, is on the staff of a hospital or residential home in which the woman is an in-patient. This applies to any mental disorder. The same prohibition applies to Guardians.

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Article 37 of the Health and Personal Social Services (Northern Ireland) Order 1972 makes provision to allow the removal to suitable premises of 'persons in need of care and attention'. It is usually only applicable in situations of self neglect and where the risk to the person's health is so great that intervention is deemed necessary although there is not a clearly defined mental disorder sufficient to require admission for assessment under the Mental Health (Northern Ireland) Order 1986.

Public health legislation may be used in circumstances where a person who is vulnerable is living in conditions of extreme squalor. An Environmental Health Officer from the local Council would carry out an assessment and issue an Improvement Notice. This notice is served on the person responsible for the property, for example, the landlord. The Environmental Health Department should be approached for advice.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 empowers the Regulation and Quality Improvement Authority to register and inspect residential care homes and nursing homes based on care standards.

The Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003 (POCVA) commenced in April 2005 and provides the legislative basis for the maintenance of a list of individuals who are considered unsuitable to work with vulnerable adults.

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## Civil Law

This includes family law and property law.

The Enduring Power of Attorney (Northern Ireland) Order 1987 enables people, while they are still mentally capable to decide who they would like to deal with their affairs on their behalf, should they become mentally incapable. The Court of Protection has powers to revoke an enduring power in the event of its abuse.

The Family Homes and Domestic Violence (Northern Ireland) Order 1998 is designed to provide a coherent legal approach to deal with two separate, but related, issues; providing protection from violence or molestation in families and regulating occupation of the family home when a relationship breaks down.

The main features of this legislation in relation to adult protection are:

- (i) it replaces the provisions under previous legislation with a single set of remedies which both improve and extend the level of protection available;
- (ii) a Non-Molestation Order and Occupation Order replace Personal Protection, Ouster and Exclusion Order. 'Molestation' is to be broadly interpreted and will be viewed on a case-by-case basis;
- (iii) the range of people who can apply for a Non-Molestation Order is extended to include parents, grandparents or friends sharing a house. However, an Occupation Order can only be made in favour of a spouse, former spouse, co-habitee or former co-habitee unless the applicant has a legal share in the property;

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- (iv) Breach of Orders made for protective purposes is a criminal offence and an arrest without warrant can be made;
  - (v) provision is included to allow specified third parties (“a representative”) to act on behalf of victims of domestic violence to apply for a Non-Molestation or Occupation Order;
  - (vi) the legislation allows a Court to exclude a domestic violence perpetrator from other premises/areas apart from the family home.

The Public Interest Disclosure (Northern Ireland) Order 1998 is designed to:

*“protect individuals who make certain disclosures of information in the public interest; to allow such individuals to bring action in respect of victimisation; and for connected purpose”.*

The type of information includes disclosures of criminal offences, miscarriages of justice, endangerments to health or safety of individuals or damage to the work environment.

### **Compensation Law**

This legislation enables a private action to be taken against an individual in the Civil Courts for compensation. The criminal injuries compensation scheme enables recompense for criminal injury or damage.



## PART IV REFERENCES

1. Department of Health (2000) No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse. London: HMSO;
2. Law Commission for England and Wales (1995) Mental Incapacity, Report No. 231. London: HMSO;
3. Guidance on Abuse of Vulnerable Adults (Management Executive, Department of Health and Social Services: 1996);
4. Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults, December 2003;
5. Good Practice in Consent (Department of Health Social Services and Public Safety, 2003);
6. Mental Capacity Act 2005;
7. Achieving Best Evidence in Criminal Proceedings (Northern Ireland): Guidance for Vulnerable or Intimidated Witnesses, including Children (2003).



## PART V GLOSSARY OF TERMS


Designated Officer	<p>This is the person within the Trust deemed to be responsible for the decision to proceed under the Adult Protection Procedures and for co-ordinating any subsequent investigation which takes place.</p> <p>The title used can vary, for example, in some Trusts this person is referred to as the Adult Protection Co-ordinator. This person will usually be a Social Work Manager.</p>
Investigating Officer	<p>This is the experienced and suitably qualified professional appointed by the Designated Officer to carry out an investigation of the alleged abuse as agreed at the Strategy Discussion.</p>
Key Worker	<p>This is the professional who is appointed by the Designated Officer/Chair of formal Case Discussion meeting to monitor the Care and Protection Plan.</p>
Police Liaison Officer	<p>This is the designated person within the Police who will help determine whether a criminal offence has been committed and advise on what level of enquiry/investigation is necessary.</p>

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Crime Manager	This is the person within the Police at District Command Unit level who holds the role of Police Liaison Officer for non-sexual crimes.
Formal Case Discussion	This is the formally convened forum used to share and evaluate the information gathered in the investigation and to formulate a Care and Protection Plan for the vulnerable adult. This meeting may also take the form, for example, of a Family Group Conference or Risk Management Meeting.
Family Group Conference	This is a family centred decision making forum. It aims to enable families to take collective responsibility for decisions regarding the care and protection of family members. It involves a network of family, friends and significant others and attempts to capitalise on the knowledge, skills and resources of the family community and agency systems.
Risk Management Meeting	This is a meeting where the focus of the discussion is on the identification of a specific risk; eg the misuse of medication, and the measures necessary to reduce that risk.



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Achieving Best Evidence	This guidance is intended to assist those conducting video-recorded interviews with vulnerable or intimidated witnesses as well as giving guidance to those who are tasked with preparing and supporting such witnesses throughout the criminal justice process.
Proportionality	The intervention or limitation on any human right adopted should achieve the objective in question.
Equality of Arms	Neither party should suffer a procedural disadvantage compared with the other.

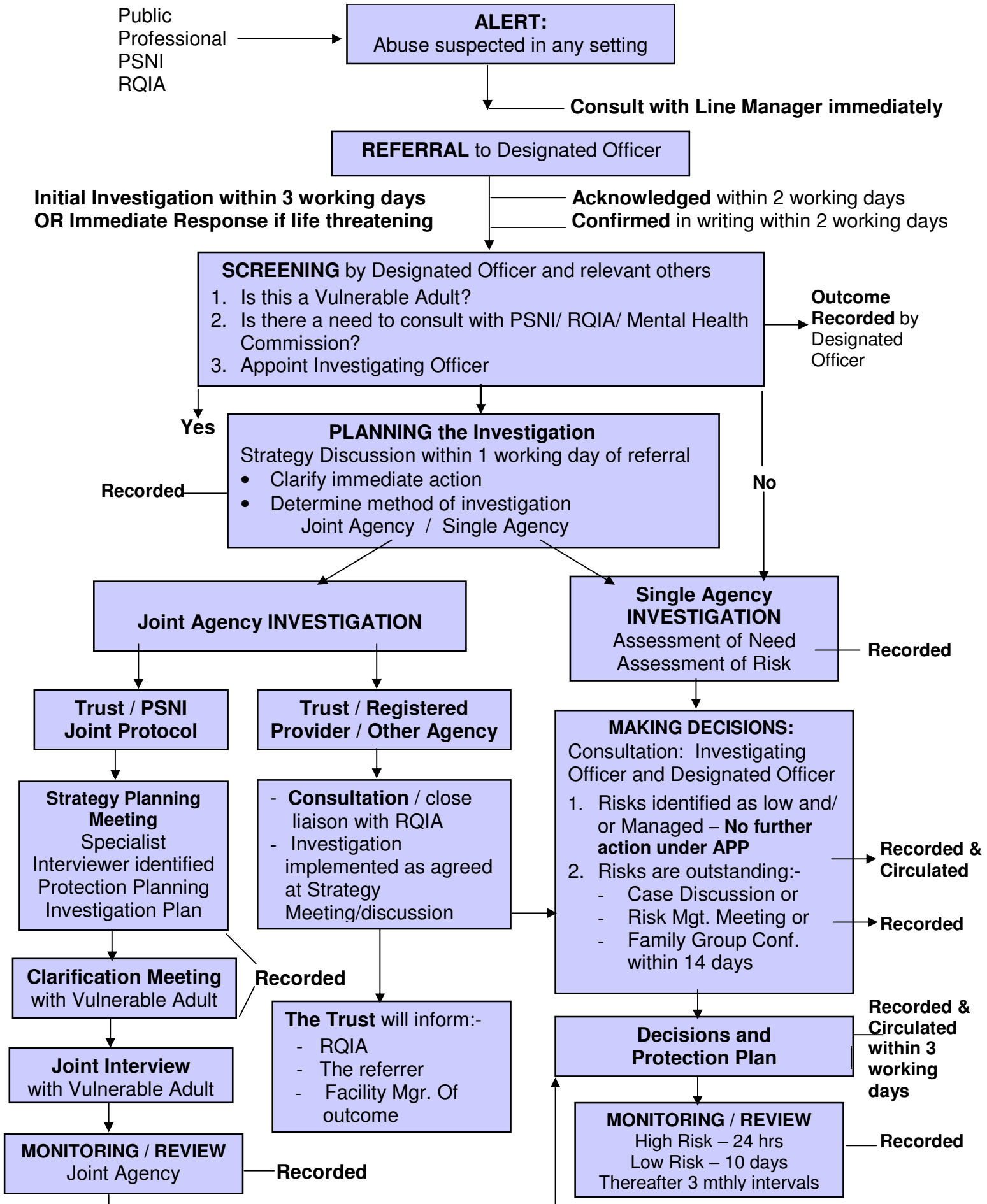


## APPENDIX

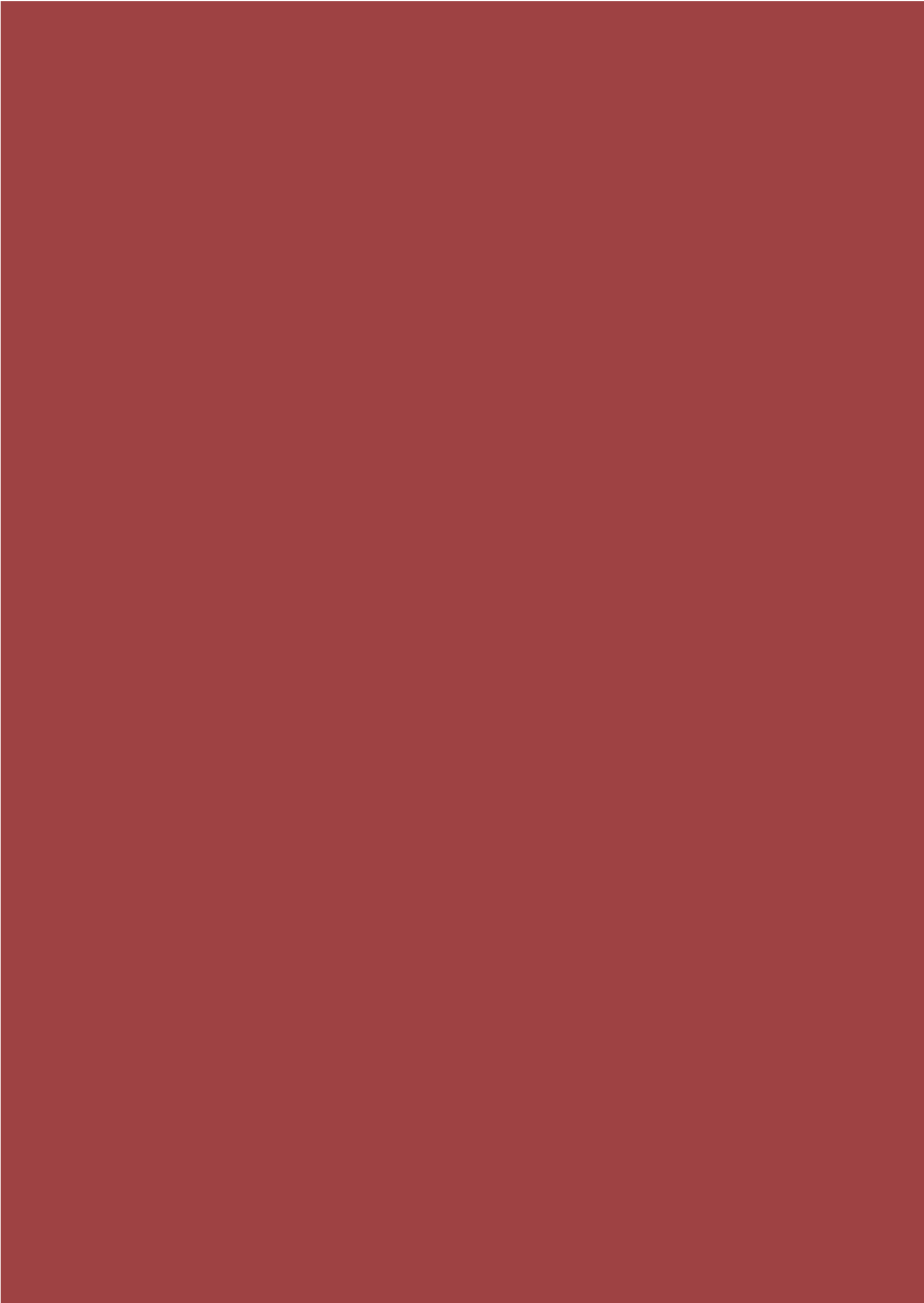
### REGIONAL ADULT PROTECTION FORUM MEMBERS

Dominic Burke	Western Health and Social Services Board
Kevin Keenan	Northern Health and Social Services Board
Jan Maconachie	Northern Health and Social Services Board
Noel Quigley	Western Health and Social Services Board
Joyce McKee	Eastern Health and Social Services Board
Dessie Lowry	Royal College of Nursing
Marian Corrigan	Southern Health and Social Services Board
Angela Cole	Ulster Community and Hospitals Trust
Brian Serplus	Homefirst Community Health and Social Services Trust
Phil Mahon	Foyle Health and Social Services Trust
Grace Henry	Help the Aged NI
Sandra Pentland	Craigavon Banbridge Community Trust
Theresa Burns	Sperrin Lakeland Health and Social Services Trust
Linda Johnston	Ulster Community and Hospitals Trust
Dr Stephen Compton	Mater Hospital Trust
Stuart Baxter	Department of Health, Social Services and Public Safety
Gary Mullan	PSNI
Kieran Downey	Sperrin Lakeland Health and Social Services Trust
Maureen Piggot	Mencap NI

# SAFEGUARDING VULNERABLE ADULTS – PROCEDURAL FLOW DIAGRAM



2nd April 2007



**Protocol for**

**JOINT INVESTIGATION**

**of Alleged and Suspected  
Cases of Abuse of  
Vulnerable Adults**

**July 2009**



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## FOREWORD

In recent years, significant efforts have been made within Health and Social Services and the Police Service to establish procedural and operational arrangements in order to respond effectively to the abuse or exploitation of vulnerable adults. This has involved a considerable degree of interagency liaison in order to develop effective partnership working which will help to prevent abuse and respond appropriately and sensitively when it is alleged, suspected or occurs.

Measures designed to support vulnerable and intimidated witnesses introduced in 2003 have contributed to even closer working arrangements between police officers and health and social services staff.

This Protocol is an important aspect of these changes. It outlines the roles and responsibilities of the respective agencies and provides guidance about joint working arrangements and investigation. It has been developed in partnership between the Police Service of Northern Ireland (PSNI), Department of Health, Social Services and Public Safety (DHSSPS), the Regulation and Quality Improvement Authority (RQIA), the Health and Social Care Trusts and the former Health and Social Services Boards in Northern Ireland. It is based on the recognition of the need for more co-ordinated interagency working to ensure that vulnerable adults, who are at risk of abuse, receive protection, support and equitable access to the criminal justice system.

The Protocol has been developed on the basis of research, best practice and on extant guidance, both regional and from elsewhere in the UK which requires agencies to develop interagency policies, procedures and joint protocols that draw on good practice and to investigate and take action when a vulnerable adult is believed to be at risk of abuse.<sup>1,2,3</sup>

<sup>1</sup> Bailey A (2001) 'Factors influencing police investigation of sexual crimes committed against people who have a learning disability and implications for public policy'.

<sup>2</sup> 'No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse'. Home Office/DOH 2000.

<sup>3</sup> 'Safeguarding Vulnerable Adults Regional Adult Protection Policy & Procedural Guidance', September 2006.

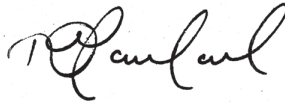


Although other agencies will be involved in aspects of the investigative process, the PSNI, Trusts and the RQIA have traditionally taken the lead roles in investigating abuse and reporting crimes. The Protocol has been designed as a basis for improved interagency working and will need to be closely monitored, reviewed and revised in the light of experience. It is supported by an ongoing programme of interagency training.

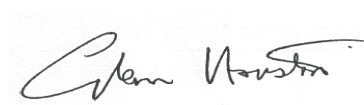
We commend this Protocol to all who are involved in this critical and demanding area of work and would like to place on record our thanks to all who contributed to its development.



Chief Executive  
Health and Social  
Care Board



Assistant Chief  
Constable Criminal  
Justice  
Police Service of  
Northern Ireland



Chief Executive  
Regulation and Quality  
Improvement Authority

# 1 Introduction

- 1.1 The PSNI and Health and Social Care (HSC) bodies are committed to tackling abuse in all its forms and to the development of collaborative working which will enhance arrangements for the protection and support of vulnerable individuals and groups. This will include responding to the specific needs of vulnerable and intimidated victims of crime. In 1998, the Home Office published a report prepared by an Interdepartmental Working Group on the treatment of vulnerable victims and witnesses, entitled 'Speaking Up for Justice'.<sup>4</sup> The report recommended that the existing special measures introduced for children, e.g. live CCTV links and video recorded evidence-in-chief, be extended to include vulnerable adults.
- 1.2 The subsequent enactment of the Criminal Evidence (Northern Ireland) Order in 1999 (the 'Criminal Evidence Order') made provision for these arrangements, or 'special measures' to be introduced locally. Guidance on the application of special measures can be found in 'Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable Intimidated Witnesses, including Children' ('Achieving Best Evidence').<sup>5</sup>
- 1.3 Other statutory agencies, for example, the RQIA, and voluntary organisations may be involved in aspects of the investigative process. However, the PSNI and HSC Trusts are primarily responsible for the investigation of abuse and the protection of vulnerable adults. This Protocol is designed to ensure staff from these agencies work together in a way that ensures the well-being and rights of vulnerable adults are paramount. It also helps to ensure that people receive equitable access to justice.
- 1.4 This Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. It is important that Trust and PSNI staff read this Protocol in conjunction with 'Safeguarding Vulnerable Adults

<sup>4</sup> 'Speaking up for Justice' - Home Office (1998).

<sup>5</sup> 'Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including Children' - Home Office Communication Directorate (2002). Work is currently being done to produce a version specifically for Northern Ireland.

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Regional Adult Protection Policy and Procedural Guidance', September 2006 ('Safeguarding Vulnerable Adults'). Police officers should also be mindful of relevant PSNI Service Procedures. This Protocol extends to suspected crimes in domiciliary, community and hospital care if the victim is a vulnerable adult as defined in paragraph 2.1.

- 1.5** The Aims and Objectives (Section 3), Principles (Section 4) and Rights and Responsibilities (Section 5) set out in this Protocol extend to vulnerable adults both as victims and as witnesses.

## 2 Definition

### Definition of a Vulnerable Adult

2.1 For the purposes of this Protocol the definition of a vulnerable adult has been taken from 'Safeguarding Vulnerable Adults'. It applies to adults:

- a) **who are 18 years old and over; and**
- b) **who are, or may be, in need of community care services OR are resident in a continuing care facility by reason of mental or other disability, age or illness OR who are, or may be, unable to take care of themselves, OR unable to protect themselves against significant harm or exploitation.**

2.2 This is more inclusive than the definition of vulnerability contained in the Criminal Evidence Order. It is likely that some cases of alleged or suspected abuse against vulnerable adults will require a joint approach to investigation but will not qualify for the special measures outlined in the Order in relation to accessing the criminal justice system. It should also be borne in mind that the human and civil rights of the individual may have been breached.

2.3 'No Secrets' which was produced by the Department of Health, London and the Home Office offered a brief definition of abuse as being:

**'the violation of an individual's human and civil rights by any other person'.**

The original DHSS guidance, produced in 1996 as a basis for developing Board and Trust adult protection policies, offered a more detailed definition of abuse as being:

**'the physical, psychological, emotional, financial, sexual maltreatment or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is the expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be informal or formal carers, staff or family members or others. It can occur outside such a relationship'.**

## 3 Aims and Objectives

- 3.1** The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.
- 3.2** The Protocol aims to:
- ensure effective communication and collaboration between Trusts, RQIA and PSNI to protect vulnerable adults;
  - involve Trusts and PSNI in determining whether a single agency or a joint agency investigation is required;
  - provide a framework for early consultation, cross referral of appropriate cases and joint working arrangements for investigation and interviewing;
  - define the roles and responsibilities of PSNI and Trust staff in the joint investigation;
  - minimise the number of interviews conducted with the victim; and
  - ensure that protective measures are paramount and run in parallel with the criminal inquiry or any other lines of enquiry, such as civil action or disciplinary proceedings.

## 4 Principles

4.1 The Protocol aims to promote the following principles in protecting vulnerable adults from abuse and the investigation of alleged or suspected crimes:

- the well-being and rights of the vulnerable adult are paramount;
- the processes should minimise distress to the vulnerable adult by maximising co-operation between agencies;
- adult protection procedures must be properly followed; and
- mechanisms should be available to resolve differences of opinion amongst staff/agencies through appropriate management structures.

## 5 Rights and Responsibilities

**5.1** The Protocol is also committed to ensuring that the rights of vulnerable adults are upheld. These include the right to:

- receive protection for themselves and their property under the law;
- be supported in reporting the circumstances of any abuse;
- have alleged, suspected or confirmed cases of abuse thoroughly investigated as a matter of urgency;
- have options for resolution and the appropriate processes explained to them;
- be supported in making decisions about how they wish to proceed in the event of abuse and to be kept informed of progress;
- have issues of consent and capacity considered;
- be given information in accessible formats on how to protect themselves;
- be given practical help in protecting themselves;
- be supported when deciding whether to pursue a formal complaint;
- be subjected to the minimum degree of disruption; and
- receive support on a longer-term basis, following the abuse.

**5.2** In order to promote these rights effectively PSNI, Trust and RQIA staff must be aware of their responsibilities in this very difficult area of work. If an allegation of abuse does not appear to relate to criminal conduct, there is no statutory duty to report the matter to the PSNI and the decision about whether or not to investigate should be judged on the 'best interest' test. In the case of non-criminal matters it may not be in the best interests of the vulnerable adult to investigate if the person has specifically indicated a preference for no investigation. However, in reaching this conclusion, it is necessary to take into account the capacity of the person making the decision and any other regulatory or personnel arrangements, e.g. disciplinary procedures, referral to a

professional body such as the Northern Ireland Social Care Council (NISCC); etc.

- 5.3** Although all members of society are duty bound to report offences, this Protocol requires staff to consider the cross-referral of alleged or suspected offences. In general, the PSNI is authorised to investigate alleged or suspected criminal abuse against the vulnerable adult where this is agreed to be in the best interests of the person. In the majority of cases, in particular where the vulnerable adult is deemed to have capacity, the PSNI will only proceed with the consent of the vulnerable adult. In practice this means that the vulnerable adult should be willing to make a complaint to the PSNI. However, there are some exceptions to this e.g. where the vulnerable adult is deemed not to have capacity, is subject to undue influence or where others may be at risk. In some circumstances the PSNI may also intervene to prevent a crime being committed.
- 5.4** Where criminal abuse may have been committed a referral between the agencies should be made and an agreed strategy should be developed which takes account of the wishes of the alleged victim. The PSNI and Trust should work sensitively in these enquiries and must secure the co-operation and consent of the victim unless there may be issues in relation to capacity and/or the potential for abuse to third parties. After referral between agencies the agreed strategy should take account of the wishes of the alleged victim. When there are concerns, but no real grounds to suspect that an offence may have been committed, there is a duty on Trust staff to investigate and report any criminal offences or concerns that may be identified as a result of the investigation.
- 5.5** When judging whether the individual has capacity to give or withhold consent, guidance in 'Safeguarding Vulnerable Adults' should be followed. This should take into account professional opinion as appropriate e.g. psychiatrists, psychologists, GPs, nurses and social workers.
- 5.6** The Human Rights Act 1998 has been fully effective from 2<sup>nd</sup> October 2000. It incorporates the European Convention for the Protection of Human Rights and Fundamental Freedoms into United Kingdom Domestic Law. This makes it unlawful for public authorities to act in a manner which is incompatible with the rights and freedoms guaranteed by the Convention. **Appendix 1** sets out the main Convention Rights enshrined in the 1998 Act.



Public authorities can interfere with an individual's rights providing it is lawful, proportionate and necessary in a democratic society.

**Lawful** means 'prescribed by law' and the legal basis for any restriction on rights and freedoms must be established and identified.

**Proportionate** means any interference with a Convention Right must be proportionate to the intended objective and not arbitrary or unfair.

**Necessary in a Democratic Society** means (1) Does it fulfil a pressing social need? (2) Does it pursue a legitimate aim? and (3) Is it proportionate to the aims being pursued?

### **The Decision Making Process**

In applying the key principles of lawfulness, proportionality and whether it is necessary in a democratic society, a public authority representative must ask the following questions:

- Is there a legal basis for my actions?
- Is it proportionate and necessary in a democratic society?
- Is the procedure involved in the decision-making process fair and does it contain safeguards against abuse?
- Was there an alternative and less restrictive course of action available? (The intervention should be strictly limited to what is required to achieve the objective).
- Is the restriction required for legitimate purposes?
- If I fail to interfere with this individual's rights could there be a more serious outcome in not affording the individual adequate protection in fulfilment of their Article 2 rights?

Decisions to interfere with an individual's rights may be subject to scrutiny by the Courts. However, if public authorities can show that they applied the relevant Human Rights principles when making their decision, they are less likely to be over-ruled. It is very important to keep notes and decisions should be recorded in full (see **Appendix 2**).

## 6 Reporting

- 6.1** This Protocol is designed to be compatible with current ‘Safeguarding Vulnerable Adults’ guidance in requiring all staff to report suspected, alleged or confirmed instances of abuse. It provides a framework within which staff exercise their professional judgement and discharge their legal responsibility. It ensures that all cases are given appropriate consideration and are not screened out inappropriately. Added safeguards to prevent this include the requirement to report cases to a designated adult protection officer (‘Designated Officer’) and to consult, where necessary, with the relevant Police Liaison Officer (see paragraph 6.6). Where a crime is suspected or alleged and the vulnerable adult does not wish to make a formal complaint, the agencies should consider the following factors:
- the individual’s capacity to provide consent to a formal complaint;
  - the opportunity to prevent crime being committed;
  - the extent to which other vulnerable persons, including children, are likely to be at risk; and
  - whether the vulnerable adult is subject to undue influence or coercion.
- 6.2** A referral to the PSNI does not automatically mean that a joint investigation will be initiated. Such a decision should involve discussion with the Police Liaison Officer. Where the PSNI is informed directly of suspected abuse which is clearly non-criminal, the individual should be made aware of other sources of support and options to have the matter resolved and his/her agreement sought to refer to the Trust.
- 6.3** Alleged or suspected instances of abuse occurring in a regulated service must be reported to the RQIA. The RQIA must ensure that alleged or suspected instances of abuse in regulated services are referred to the PSNI and the appropriate Trust.
- 6.4** Reports of alleged or suspected abuse, which may be a criminal offence, will be categorised as:
- (a) **Sexual** (e.g. rape, indecent assault); or
  - (b) **Non-sexual** (e.g. physical assault, theft).

The PSNI will be responsible for determining the category of offence.

**6.5** Where alleged or suspected crimes are reported to the PSNI they have a duty to conduct criminal investigations. The decision to investigate will be made at a Strategy Discussion and will be informed by the views of the victim and Trust staff.

### **6.6 Referral to PSNI by Health and Social Care Trusts**

- a) In all cases of alleged or suspected criminal abuse the Designated Officer for the Trust should discuss the case with the relevant Police Liaison Officer. It will be the responsibility of the Police Liaison Officer to help determine whether the matter may involve criminal abuse and thereby to inform the decision concerning what level of enquiry/investigation is necessary.
- b) Alleged or suspected abuse, whether sexual or non-sexual, should be reported to the Inspector, Public Protection Unit (PPU) or nominated deputy who holds the role of Police Liaison Officer. The Inspector or nominated deputy will allocate any investigation regarding the alleged abuse whether it is uniform or the Criminal Investigation Department (CID).
- c) Outside of PPU working hours (9.00 am – 5.00 pm Monday to Friday), the Duty Inspector in the relevant district should be contacted who will determine what preliminary action is required. In all such reported cases of alleged abuse the Duty Inspector will inform the PPU Inspector or nominated deputy as soon as is practicable.
- d) A list of contact numbers for the PPU's is contained in **Appendix 3**.

### **6.7 Referral to Health and Social Care Trusts by PSNI**

- a) Police officers who encounter vulnerable adults who may have been the subject of abuse, whether criminal or not, should contact the relevant Designated Officer to establish whether the vulnerable adult is known, or should be referred, to the Trust.
- b) Where concerns are raised in relation to the care or treatment, which may involve criminal abuse of a vulnerable adult outside normal working hours (9.00 am - 5.00 pm Monday to Friday),

these concerns should be referred immediately to the Out-of-Hours Social Work Co-ordinator (the Co-ordinator).

- c) The Co-ordinator will take whatever action is necessary to ensure the protection of the vulnerable adult. Depending on the scale of the concern this may involve referral to other agencies. The Co-ordinator will make the appropriate Designated Officer for the Trust aware of the referral details and any action taken/required, as a matter of urgency on the first working day following the date of the referral being made.
- d) Contact details for Trusts and contact points for Out-of-Hours Services can be found in **Appendix 4**.

### **Alleged or Suspected Criminal Abuse in a Regulated Service**

- 6.8** When criminal abuse is alleged or suspected to have occurred in a regulated service and is reported to, or comes to the attention of the RQIA, the relevant programme head at the RQIA should ensure that the matter is referred to both the Police Liaison Officer and to the relevant Trust Designated Officer as soon as is practicable (see **Appendix 5** for contact details). If an incident of suspected or alleged criminal abuse in a regulated service comes to the attention of Trust staff, the RQIA must be informed by the Designated Officer as soon as is practicable.

### **Referral from PSNI to RQIA**

- 6.9** Police officers, who encounter a vulnerable adult who is a service user within a regulated service and who may have been subjected to abuse, whether criminal or not, should contact the relevant Trust Designated Officer and RQIA. This will enable RQIA to establish if there has been any breach in the relevant legislation that requires regulatory action.

### **Inappropriate Referral**

- 6.10** In any event where a referral is made inappropriately between agencies the receiving agency will have responsibility for referring the matter to the appropriate agency.

## 7 Initial Assessment Consultation - Planning and Investigation

### Clarification of Roles

- 7.1** The PSNI and Trust staff have specialist and complementary skills in terms of assessing and investigating allegations of abuse of vulnerable adults. The process is outlined in **Figure 1** (see page 17). In appropriate cases it is necessary to combine these skills to provide maximum protection and support for those individuals who have been the subject of, or are at risk of harm. This Protocol recognises that the various agencies may have different priorities or emphasis in relation to adult protection work.
- 7.2** The Protocol is not designed to make Trust or PSNI personnel undertake roles which are at variance with their primary professional responsibilities. However it is intended to provide a basis for maximising co-operation and a shared understanding of the issues involved. Differences of opinion, or approach, amongst staff should be resolved in a manner that does not hinder the protection of the vulnerable adult. Protection of the individual is paramount and staff should not inappropriately screen out cases by failure to follow this Protocol.
- 7.3** The strategy to be adopted must be informed by the professional views of PSNI, Trust and, as appropriate, RQIA staff. The strategy for investigation should always be influenced by information gained from professionals or other persons who may have knowledge of the vulnerable adult, his/her family or circumstances.
- 7.4** The primary objective of PSNI, Trust and RQIA is the protection of the vulnerable adult. In addressing this shared objective, the primary role of PSNI personnel is determined by their statutory responsibility to protect life and property, preserve order, prevent crime and, where a criminal offence has been committed, bring offenders to justice.
- 7.5** The primary role of Trust and RQIA staff is determined by their statutory responsibility and Duty of Care, to promote the care and well-being of vulnerable adults in situations of alleged or confirmed abuse.

- 7.6** Assaults (including minor assaults), thefts, criminal damage, sexual assaults and threats of force or violence are all likely to be criminal offences. PSNI and Trust staff must recognise that the non co-operation of the victim does not always preclude a prosecution. However, the views of the victim are vital to the decision to prosecute.

### **Joint Agency Consultation**

- 7.7** When either Trust or PSNI personnel identify the need for a joint agency approach, a staff member from the referring agency will take responsibility for instigating a Joint Agency Consultation. This should be the person within the Trust deemed to be responsible for the decision to proceed in cases of alleged or confirmed abuse. The Designated Officer will take responsibility for co-ordinating the practical arrangements associated with this action.
- 7.8** The purpose of the Consultation is to discuss the case with other relevant agencies and organisations and to reach a decision on the need for a Joint Investigation involving Trust and PSNI. This communication may be by telephone or direct contact and should occur within 24 hours of the decision that Consultation with the other agency is necessary.
- 7.9** The outcome of this Consultation may be:
- no further action;
  - a Trust investigation;
  - a criminal investigation by PSNI; or
  - a Joint Investigation involving Trust and PSNI.

The results of this Consultation must be clearly recorded and shared between agencies. Form AJP1 - Record of Joint Agency Consultation (**Appendix 6**) should be used for this process. The completion and appropriate sharing of this and other records, e.g. Form AJP2 - Strategy for Investigation (**Appendix 7**) and Form AJP3 - Clarification Discussion (**Appendix 8**) is the responsibility of the lead agency in the investigation. Where it is agreed that a Trust investigation is appropriate the guidance contained in 'Safeguarding Vulnerable Adults' should be followed.

## **Criteria for Joint Investigation by Trust and PSNI**

**7.10** A detailed consideration of the need for a Joint Investigation will be triggered when there is an allegation or suspicion that one of the criminal offences described below has been committed against a vulnerable adult. The likelihood or otherwise of a prosecution is not a criterion for a Joint Investigation.

- A sexual offence committed against a vulnerable adult;
- Physical abuse or ill treatment amounting to a criminal offence;
- Financial abuse involving a criminal offence, e.g. fraud, theft; or abuse which involves a criminal offence e.g. blackmail.

## **Preliminary Information Gathering**

**7.11** Following the decision of the Joint Agency Consultation to initiate a Joint Investigation, each agency will nominate a staff member to gather information for the Strategy Planning Meeting which will be the basis for planning any subsequent investigation. The nominated officer will carry out checks on internal systems for information that may be of use in deciding the strategy to be employed. At this stage consideration must be given to the communication needs of all those involved.

## **Strategy Planning Meeting**

**7.12** When sufficient preliminary information is available to facilitate the development of a strategy for dealing with the case, a Strategy Planning Meeting should be convened. This should occur as soon as is practicable. The responsibility for convening this meeting lies with the designated staff member who initiated the Joint Agency Consultation.

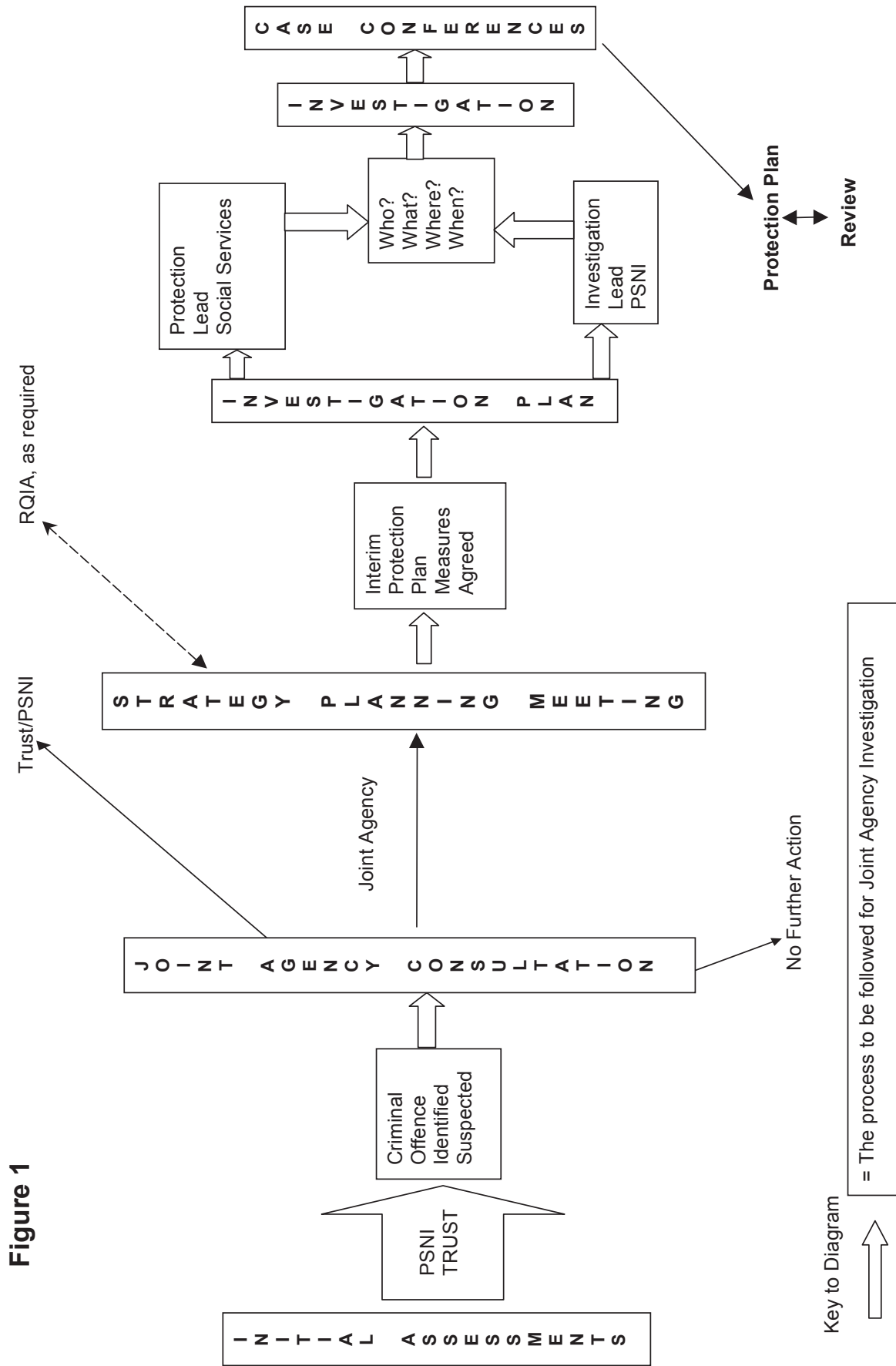


Figure 1



**7.13** The purpose of the Strategy Planning Meeting is to ensure an early exchange of information and to clarify what action needs to be taken jointly or separately in the investigation. It is an action orientated discussion, which should be convened to plan the investigation and agree any necessary interim protection measures.

**7.14** A Strategy Planning Meeting will always include PSNI, Trust and RQIA staff, where appropriate. Other professionals, agency representatives and persons with specialist knowledge/skills may also be included to ensure the protection of the vulnerable adult.

**7.15** Where the Strategy Planning Meeting concludes that a vulnerable adult has been the victim of criminal abuse or may be at risk of serious criminal abuse and that issues arise about the protection of the individual, the Strategy Planning Meeting should address the following points:

- whether action is needed to protect the vulnerable adult and who will be responsible for such action;
- the need to consider the issue of capacity to consent and the most appropriate person to deal with it;
- the requirement for a medical examination to be undertaken and if so, by whom;
- what issues of special needs, race, culture, gender, language, communication or religion are raised in the case, how and by whom they are to be addressed and what advice needs to be sought;
- what specialist support or advice may be needed and who obtains it;
- what other information is needed to complete the investigation and who will seek it;
- the order in which the interviews will take place and who will carry out each interview;
- practical arrangements for reporting back to those involved in the investigation; and

- refining internal processes for communication and agreeing the communication strategy, and who should lead it, where there are matters likely to be of public interest.

**7.16** It is the responsibility of the person who convenes the meeting to ensure that a record of the Strategy Planning Meeting is made and shared between agencies. Form AJP2 - Strategy for Investigation (**Appendix 7**) should be used for this purpose. Although strategy planning will generally take place in a formally constituted meeting, there may be occasions where this may need to be conducted by telephone.

## **8 Joint Investigation Interviews**

- 8.1** Interviews with vulnerable adults will be conducted in accordance with the guidelines contained in 'Achieving Best Evidence'.

### **Joint Interviews by Police Officers and Social Workers**

- 8.2** Where it is agreed in the Strategy Planning Meeting that interviews should be conducted jointly by a police officer and social worker the following procedures will apply. It must be emphasised that the decision about which interviews should be conducted jointly, and the sequence of interviews, is a matter for the group planning the investigation at the Strategy Planning Meeting.

### **Selection of Interviewers**

- 8.3** Only PSNI and Trust personnel, who have received specialist training in joint interviewing, should be appointed to the task. Where a vulnerable adult has requested the interviewer to be of a specific gender all reasonable steps must be taken to facilitate this request.

### **Supervision of Interviewers**

- 8.4** It will be the responsibility of each agency to ensure that the interview and investigation process is properly supervised and supported by relevant managers who have been trained in these procedures.

### **Clarification Discussion**

- 8.5** In making decisions about the method of interviewing vulnerable adults it may be necessary to have a short Clarification Discussion. This should normally be undertaken by the persons who will conduct any subsequent interview. However, where this is not possible, the Clarification Discussion may be carried out by other staff who have received Joint Protocol training. Once a decision has been made that an interview of a vulnerable adult should be conducted on video, a specialist investigative interviewer will be tasked to carry out the interview.

### 8.6 The purpose of the Clarification Discussion is:

- to establish whether or not the vulnerable adult has made an allegation or raised suspicions which have led to the referral. The substance and detail of the allegation or disclosure should not be part of the Clarification Discussion;
- to assess the vulnerable adult's willingness and ability to pursue the matter to court;
- to inform the PSNI decision about which format should be used for the interview, (e.g. videotape, statement or question and answer. Videotaping is the preferred method of interviewing vulnerable adults. Statements are the alternative and questions and answers should only be used when neither videotaping or statements are possible) and whether the use of video in the interview is likely to maximise the quality of that particular vulnerable adult's evidence.

**8.7** The Clarification Discussion must be recorded and responsibility for this will lie with the person conducting it. The Clarification Discussion is not an investigative interview and should never replace or over-shadow the Joint Investigation interview with the vulnerable adult. Strictly no further examination of the allegation should take place beyond that which has been disclosed. It is important not to coach the interviewee in respect of the interview. If the discussion includes the disclosure of a criminal offence, that part must be recorded verbatim and contemporaneously, or at the very least as soon as possible after the contact. Even if no criminal disclosure is made, accurate recording is essential. Decisions about risk may be made on the strength of the Clarification Discussion. Form AJP3 (**Appendix 8**) must be completed in respect of every Clarification Discussion.

### **Preparation for a Joint Interview**

**8.8** The following should be considered when preparing for a Joint Interview:

- the needs and circumstances of the vulnerable adult (e.g. development, impairments, degree of trauma experienced, whether he/she is now in a safe environment);
- the vulnerable adult's state of mind (e.g. likely distress, and/or shock);

- perceived fears about intimidation and recrimination;
- the circumstances of the suspected offence (e.g. relationship of the vulnerable adult to the alleged offender);
- location of interview;
- time of interview;
- preferred gender of interviewer; and
- additional requirements (e.g. preparation of staff and interpreters).

**(Note:** Where a language barrier exists an independent interpreter should be used as opposed to a family member).

Other persons with specialist skills may be needed to assist the interviewer conduct the interview. This might include, specialist communicators using sign language, etc.

## **8.9 Purposes of the Joint Interview**

The purposes of the Joint Interview are to:

- promote the well-being and protection of the vulnerable adult;
- validate or negate allegations or suspicions of abuse by helping the vulnerable adult to give as much information as possible;
- avoid multiple interviews where possible;
- identify the suspected abuser;
- ensure that all decisions made are based on the experience of the vulnerable adult and not the influence or beliefs of the interviewer; and
- provide a record of the vulnerable adult's evidence-in-chief which may be used at a consequent criminal hearing.

## Persons Present at Joint Interview

- 8.10** Normally no-one else should be in the interview room apart from the vulnerable adult and the interviewers. Limiting the number of people present at the interview should lessen the possibility of the vulnerable adult feeling overwhelmed by the situation and uncomfortable about revealing information.
- 8.11** It is good practice for the vulnerable adult to know that a supportive person is available in an adjoining room. A suspected offender should never be present in an interview. However, if it is the vulnerable adult's wish to have a supportive person present in the interview room it should be made clear to that person that he/she must take no part in the interview.

## Recording Information that is not Video Recorded

- 8.12** When a Joint Interview with a vulnerable adult is not video recorded a written account of the information given should be made. If it is assessed by the interviewers, or on the basis of consultation with other expert opinion, that the vulnerable adult is capable of giving an account of relevant matters, the police officer may invite the adult to make a signed, written statement on Form 38/36. The evidence of a vulnerable adult who is not capable of making a statement should be recorded as questions and answers and certified by them and any other person present.

## The Video Interview

- 8.13** The Criminal Evidence Order provides for the video recording of interviews with vulnerable adults to be admitted as evidence-in-chief at criminal proceedings. The guidance accompanying the legislation is designed to help those police officers and any Trust staff involved in making a video recording of an interview with a vulnerable adult, where it is intended that the result should be admissible in criminal proceedings.
- 8.14** The Order is 'Permissive' legislation. There should be a general assumption that a video interview will be conducted where the criteria are met (e.g. an eligible witness in an indictable [Crown Court] case). Use of a video for interviews is not necessary in all cases and, on occasions, might add to the interviewee's trauma unnecessarily. The decision as to whether the interview will be videotaped will be taken by

the investigating police officer in consultation with Trust staff following the Clarification Discussion.

### **Planning the Joint Interview**

**8.15** In order to be fully and properly prepared for an interview the Joint Investigation Team of PSNI and Trust staff should normally plan the interview in line with the 'four phased' approach set out in 'Achieving Best Evidence' and adhere to the criteria which it has identified. The four phases are:

- **Rapport;**
- **Free Narrative;**
- **Questioning; and**
- **Closure.**

**8.16** Planning should include deciding whether PSNI or Trust team member should take the role of lead interviewer, the proposed time scale, any special arrangements/allowances which are required to take account of the vulnerable adult's individual difficulties, agreed signals on when to take breaks or terminate the interview. As video recording of investigative interviews is aimed at providing evidence-in-chief at criminal courts, planning must include coverage of the 'points-to-prove' in criminal offences.

**8.17** Where it appears, before interviewing a vulnerable adult, that the history of the case indicates a considerable amount of information is likely to be forthcoming, a series of interviews may be planned. The second, third, etc, interviews in this series will be considered part of the original interview without any automatic need to consult with the Public Prosecution Service (the PPS).

**8.18** The Joint Investigation Team must be given sufficient time to carry out this planning process, prior to a Joint Investigative Interview. Failure to do so may limit the effectiveness of the process and do a disservice to the vulnerable adult. Preparation will include the following activities:

- **Technical Preparation;**
- **Consideration of Consultation with Specialists; and**
- **Consideration of Communicative Competency of Vulnerable Adult and Interviewer.**

## **Technical Preparation**

- 8.19** The Joint Investigation Team will need to carefully prepare for the interview, ensure that the equipment is in working order, test for vision and sound quality and ensure that tapes are correctly prepared, checked and inserted. Consideration should also be given to whether other equipment will be needed, e.g. hearing aids, communication boards, etc.

## **Consideration of Consultation with Specialists**

- 8.20** The Joint Investigation Team should consider the conclusions of the Clarification Discussion about the need to involve staff with specialist skills in the Joint Investigative Interview and any role they should take in it. Due to the nature of this type of investigative interviewing it will often be necessary to seek specialist assistance with issues such as communication difficulties, mental ill-health or learning disability. If a specialist is asked to facilitate the Joint Interview, he/she should be informed of the purpose of the interview and the limitations placed on his/her role.
- 8.21** If an interpreter is required to assist in criminal proceedings involving a vulnerable adult who uses sign language the person must have attained at least Stage 3 British Sign Language or Irish Sign Language qualification, as appropriate.

## **Consideration of Communicative Competency of Vulnerable Adult and Interviewer**

- 8.22** The vulnerable adult and interviewers need to be able to achieve the minimum requirements for communication. The Joint Investigation Team must establish whether a vulnerable adult has a reliable method of communication which he/she can use intentionally and that the interviewers can understand either directly or via a suitable interpreter.
- 8.23** If the vulnerable adult has specific difficulties with comprehension or use of language (vocabulary, ideas and grammar) associated with physical or intellectual impairment careful consideration must be given to how these could be overcome. Speech and language therapists, sign language interpreters or facilitators in augmentative communication may be required.
- 8.24** The competency of the interviewers in communicating will be the single greatest factor in determining whether a vulnerable adult will be able to deal with, and participate effectively in, an interview situation. The



interviewer will also require information about the vulnerable adult's knowledge and understanding of him/herself, about objects, about places and events and how these things may be affected by his/her impairment or disability.

### **Conduct of the Interview**

**8.25** The interviewers need to provide the vulnerable adult with information at a level which will help him/her to understand who and what will be involved. Initially they should cover:

- introduction of the social worker (or other professional), the police officer and any other person who requires to be present, with an explanation of each of their roles;
- an explanation of the purpose of the interview in a sensitive way that the vulnerable adult can understand;
- an acknowledgement that it is a difficult situation for the vulnerable adult and that some things, particularly sexual assault, may be difficult to talk about; and
- introduction of the video equipment and seeking consent to use it in the interview.

**8.26** The following are categories of facts, which, if contained in the vulnerable adult's evidence, will enable properly informed decisions to be taken regarding the subsequent conduct of the investigation and ultimately whether or not to prosecute any person for any offence committed against the vulnerable adult:

- name/identity of the alleged abuser/offender, his/her present whereabouts, and the relationship of that individual to the vulnerable adult;
- the duration and extent of the abuse/offence;
- what happened in detail, when it happened, where, and how often, being mindful of the 'points-to-prove' for each offence;
- date/time of last occurrence, likelihood of physical evidence;

- names/identity of anyone else having knowledge of the abuse/offence;
- names of anyone else involved in, or observing, the abuse/offence; and
- identity of anyone the vulnerable adult has told about the abuse/offence.

**8.27** After the interview, the vulnerable adult and/or their representative should be given as much information as possible about what will happen next including arrangements for his/her protection. If he/she is to be interviewed again, he/she should be informed of where and when it may take place.

**8.28** If the interview or series of interviews has/have been completed and further information comes to light which makes it necessary to conduct another interview with the vulnerable adult, or where it is believed the vulnerable adult has more to tell, this should be considered a further or supplementary interview. In this case the matter should be discussed with the PPS. This will cover cases where, for example, conflicting evidence comes to light, a vulnerable adult makes further disclosures or names other suspects. 'Achieving Best Evidence' should be referred to when considering the further interview of a vulnerable adult.

**8.29** Once the interview is complete, the Joint Investigation Team should give consideration to the individual's need for any counselling or therapeutic requirements which this may have indicated. PSNI and the PPS must be informed about the nature of such therapy in each case. This is to ensure that the evidence provided to a court is not contaminated or contradicted by the vulnerable adult.

### **The Vulnerable Adult who Becomes a Suspect**

**8.30** If a vulnerable adult becomes suspected of a crime during the course of an interview, a decision will have to be made on whether to proceed or terminate the interview. The interviewers should take a short break to consult, and if necessary seek advice, on the matter, in addition to being mindful of the need for sensitive handling of the situation. If it is concluded that the evidence of the vulnerable adult as a suspect is paramount in a particular case, the interview should be terminated so that any further questioning can be carried out in accordance with the Police and Criminal Evidence (NI) Order 1989, (PACE) at an appropriate location.

## Further Interviews

**8.31** Occasions may arise where a police officer or a social worker may wish to further interview a vulnerable adult who is the victim of some criminal offence. It will be the responsibility of that police officer or social worker to advise the other agency of the intention to further interview the individual. The same procedures will apply to a further interview as apply to the original interview. No agency should unilaterally conduct further interviews with the vulnerable adult who may be central to criminal proceedings.

## Records of Joint Investigative Interviews

**8.32** PSNI staff will retain a written statement, recorded as a Joint Interview, for evidential purposes. A copy may be provided to Trust staff, provided that the vulnerable adult agrees. Where a Joint Interview has been video recorded the original will be labelled and secured for court purposes by the PSNI. The working copy will be available for viewing by Trust staff by arrangement with the officer-in-charge of the case. A log will be completed on each occasion that the tape is viewed by anyone and will detail the reasons for it having been viewed. This will be retained with the working copy of the tape.

**8.33** Arrangements for viewing the tape by persons other than those identified above, e.g. defence or any subsequent court hearing will be the responsibility of the PSNI. PSNI General Order C(c) 70/96 must be complied with. Where investigation involves PSNI and HSC participation, the police officer in the case will be responsible as the prime keeper of all exhibits, letters, drawings, notes, etc.

## Review of Ongoing Management of the Case

**8.34** When the formal Joint Interview process has been concluded there may be a need for further interagency discussions, outside of any judicial procedures, to agree a course of action to address the practical and emotional implications for the vulnerable adult, his/her carers and staff involved in the case. In the majority of cases this can be most comprehensively dealt with by convening a Case Conference, although other, less formalised, mechanisms should be considered to optimise client/family involvement in the process. This is the responsibility of the Designated Officer from the relevant Trust in consultation with PSNI colleagues. Consultation should also take place on an interagency basis to identify the need for any staff debriefing/counselling which may be required as a result of the work which has been undertaken.

# Glossary of Terms

## Glossary of Terms

### **Achieving Best Evidence**

A voluntary code of practice for interviewing vulnerable witnesses for criminal proceedings and where video is used to record the witness' testimony.

### **Case Conference**

Is a meeting of those involved in a case which can include the client/victim. The purpose is to establish potential risk to the individual and what action, if any, would be required.

### **Criminal Investigation Department (CID)**

Police team of Detective Officers based in each District Command Unit with responsibility for the investigation of crime other than sexual crime.

### **Cross Examination**

The secondary stage of evidence giving in Court where the testimony that a witness has already given is examined by counsel for the defence.

### **Counsel for the Defence**

The legal representative responsible for conducting the case for the defence.

### **Designated Officer**

Person within the Trust responsible for managing investigations of suspected, alleged or confirmed instances of abuse against vulnerable adults.

### **District Command Units**

There are eight District Command Units in Northern Ireland headed by a Chief Superintendent.

### **Evidence**

The term 'evidence' in its legal sense embraces all matters exclusive of mere argument, which can be placed before a Court to prove or disprove any matter or fact, the truth of which is the subject of judicial investigation.

## **Evidence-In-Chief**

The initial stage of giving evidence in Court where the witness is taken through their evidence by counsel for the prosecution.

## **Form 38/36**

Form used by PSNI for making a written record of witness evidence when video is not seen as an appropriate form of recording - known as 'a statement'.

## **Hearsay Evidence**

Evidence of what a person has heard another person, not the accused, say. It is not admissible in criminal proceedings.

## **Investigating Officer**

Trust professional with responsibility for investigating the alleged abuse. Their role is to establish the facts, look at alternatives available and to provide counselling and support.

## **Line Manager**

Management grade within the Trust to whom an individual directly reports.

## **Live Television Link**

A system allowed under the Police and Criminal Evidence (NI) Order 1989 whereby certain witnesses can give evidence from a television monitor in a room separate from the main body of the Court.

## **NISCC (Northern Ireland Social Care Council)**

NISCC is the independent regulatory body for the Northern Ireland Social Care workforce, established to increase public protection by improving and regulating standards of training and practice for social care workers.

## **Nominated Officer**

The agency staff member with the delegated role of gathering information for the Strategy Planning Meeting which will be the basis for planning any subsequent investigation. The nominated officer will check internal systems for information that may be of use in deciding the strategy to be employed.

## **Points to Prove**

The ingredients of a criminal offence, each of which must be satisfactorily proven in a criminal trial.

## **Police Service Procedure**

A written instruction, which is issued to the PSNI.

## **Protection Plan**

A plan developed to clarify the protection measures put in place to protect the individual. Roles and responsibilities for doing so are clearly identified.

## **Public Prosecution Service (PPS)**

A body of legal staff who work independently from the Police and who are responsible for directing on cases forwarded for prosecution or otherwise.

## **Public Protection Units (PPUs)**

Police team with specific responsibility for the following:

- Child Abuse Enquiry Unit;
- Domestic Violence;
- Management of Violent/Sex Offenders;
- Missing and Vulnerable Persons Enquiries/Investigations.

## **Regulation and Quality Improvement Authority (RQIA)**

The RQIA is the independent body responsible for monitoring and inspecting the availability and quality of Health and Social Care services in Northern Ireland, and encouraging improvements in the quality of those services. The role of RQIA is to ensure that the Health and Social Care services in Northern Ireland are accessible, well managed and meet the required standards.

## **Regulated Service**

The RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and its supporting regulations.

The services which it regulates include residential care homes; nursing homes; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; day care settings; and boarding schools.

### **Third Party Material**

Matters of potential relevance to a Police investigation, which are not in possession of PSNI.





# APPENDICES

## Appendix 1

### THE EUROPEAN CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS INTO THE UK DOMESTIC LAW

#### THE HUMAN RIGHTS ACT 1998

##### MAIN CONVENTION RIGHTS:

- Article 2 - Right to life
- Article 3 - Prohibition of torture
- Article 4 - Prohibition of slavery and forced labour
- Article 5 - Right to liberty and security of person
- Article 6 - Right to a fair trial
- Article 7 - No punishment without law
- Article 8 - Right to respect for private and family life
- Article 9 - Freedom of thought, conscience and religion
- Article 10 - Freedom of expression
- Article 11 - Freedom of assembly and association
- Article 12 - Right to marry
- Article 14 - Prohibition of discrimination
- Article 16 - Restrictions on political activity of aliens
- Article 17 - Prohibition of abuse of rights
- Article 18 - Limitation on use of restriction on rights

##### FIRST PROTOCOL:

- Article 1 - Protection of property
- Article 2 - Right to education
- Article 3 - Right to free elections

##### SIXTH PROTOCOL:

- Article 1 - Abolition of the death penalty

**NOTE: The following Articles are omitted from the Act:**

**Article 1** - **Obligation to respect Human Rights**

**Article 13** - **Right to effective remedy**

**Articles 15 - 59** - **Operational provisions for the European Court**

## Appendix 2

### HUMAN RIGHTS - List of Considerations

If you cannot answer a question, you cannot proceed to the next question. Only take action when you have completed the list.

1. Is there any necessity to take action? What are you doing? Why are you doing it?
2. Is there any legal basis upon which to take action? Is there a statutory/mandatory/discretionary power you are using? If so, state it. If not, on what basis are you taking action? (You should seek legal advice).

3. What are the Human Rights implications of the proposed action? (Go through Convention List and mark the relevant article and the relevant limitation).  
**(See Appendix 1)**

Specify Article and Limitation

4. Is the proposed action proportionate? Is the scale of the action appropriate to the size of the problem? (i.e. consider whether it is intrusive or invasive). Is there an alternative?

Give reasons for your decision

5. Is there an independent public remedy available? If not, consider what will be the effect of failure to give a remedy i.e. Ombudsman/Judicial Review/other Court action).

Specify all available remedies

6. If action is taken, is there "equality of arms"?  
Does the person have the same opportunity to gather evidence as you and present it to the Court/Tribunal?

7. Is the action the least possible one?  
Is it the least intrusive or invasive?

**POST-EVENT EVALUATION**

**Signed:**

**Dated:**

**Print Name:**

**Position/Rank:**

## Appendix 3

**Police Service of Northern Ireland - Contact Number (028) 9065 0222**  
**Contact details for referrals to PPU's between**  
**9.00 am - 5.00 pm Monday to Friday**

**A District - North and West Belfast**

Inspector Ext 28950 Sergeant Ext 28826

**B District - South and East Belfast**

Inspector Ext 23594 Sergeant Ext 23579

**C District - North and South Down, Ards and Castlereagh**

Det/Inspector Ext 31160 Sergeant Ext 15782

**D District - Antrim, Lisburn, Newtownabbey and Carrickfergus**

Inspector Ext 30321 Sergeant Ext 27630

**E District - Lurgan, Craigavon, Armagh, Banbridge and Newry and Mourne**

Inspector Ext 34022 Sergeant Ext 34017

**F District - Fermanagh, Omagh, Cookstown, Dungannon and South Tyrone**

Inspector Ext 54194 Sergeant Ext 54118

**G District - Foyle, Limavady, Strabane and Magherafelt**

Det/Inspector Ext 58565 Sergeant Ext 57019

**H District - Coleraine and Ballymena**

Inspector Ext 63901 Sergeant - Coleraine Ext 83102  
Sergeant - Ballymena Ext 63253

**In all referrals regarding Vulnerable Adults the Sergeant attached to the relevant PPU will be the first point of contact.**

**Outside of usual office hours (9.00 am - 5.00 pm, Monday to Friday) the Duty Inspector in the relevant District should be contacted.**

## Appendix 4

### Contact details for Designated Officers and Contact points for Out-of-Hours Emergency Social Work Co-ordinators

<b>HSC Trust</b>	<b>Designated Officer Contact</b>
<b>Belfast</b>	Phone: (028) 9032 7156
<b>South Eastern</b>	Phone: (028) 9266 5181 Ext 4544
<b>Western</b>	Phone: (028) 7131 4090
<b>Northern</b>	<b>Learning Disability</b> Phone: (028) 2766 1393
	<b>Mental Health</b> Phone: (028) 9441 3114
	<b>Older People</b> Phone: (028) 2563 5558
	<b>Physical Disability and Sensory Impairment</b> Phone: (028) 2766 1217
<b>Southern</b>	<b>Learning Disability</b> Phone: (028) 3752 2381
	<b>Mental Health</b> Phone: (028) 3883 1983
	<b>Older People</b> Phone: (028) 3082 5120
	<b>Physical Disability and Sensory Impairment</b> Phone: (028) 3833 3332



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**Out-of-Hours Emergency Social Work Co-ordinators - Contact Points**

Belfast Health and Social Care Trust and South Eastern Health and Social Care Trust (Knockbracken Healthcare Park)	(028) 9056 5444
Northern Health and Social Care Trust (Holywell Hospital)	(028) 9446 8833
Southern Health and Social Care Trust (Daisy Hill Hospital)	(028) 3083 5000
Western Health and Social Care Trust (Altnagelvin Hospital)	(028) 7134 5171

## **Appendix 5**

### **Contact details for the Regulation and Quality Improvement Authority between 9.00 am - 5.00 pm Monday to Friday**

The RQIA's headquarters is located in Belfast at :

The Regulation and Quality Improvement Authority  
9th Floor Riverside Tower  
5 Lanyon Place  
BELFAST  
BT1 3BT  
Phone: (028) 9051 7500

Contact details for the RQIA's Omagh office are:

The Regulation and Quality Improvement Authority  
Hilltop  
Tyrone and Fermanagh Hospital  
OMAGH  
BT79 0NS  
Phone: (028) 8224 5828

## Appendix 6

### ADULT PROTECTION: FORM AJP1 - RECORD OF JOINT AGENCY CONSULTATION

Referral by telephone on _____ / _____ / _____	
To: _____	Designation: _____
Person referring: _____	Designation: _____
Address: _____	
Contact Tel No: _____	

Name of Vulnerable Adult: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_

Home Address: \_\_\_\_\_

Present Location: \_\_\_\_\_

Gender\*: M  F

Nature of Vulnerability\*:  Frail Older Person  Dementia  Learning Disability  
 Physical/Sensory Disability  Mental Illness  Other (please specify)

Is the Vulnerable Adult subject to any legal/statutory status?\*

(e.g. Guardianship, Non-Molestation Order) Yes  No

If yes please provide details: \_\_\_\_\_

Details of any current or past involvement with Social Services, Police and/or the Regulation and Quality Improvement Authority: \_\_\_\_\_

Name of Carer/Next of Kin: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Tel No: \_\_\_\_\_

WHAT IS THE MAIN FORM OF SUSPECTED, ADMITTED OR KNOWN ABUSE?\*

- |   |                                  |  |
|---|----------------------------------|--|
| <input type="checkbox"/> Physical               | <input type="checkbox"/> Sexual  | <input type="checkbox"/> Psychological/Emotional |
| <input type="checkbox"/> Financial              | <input type="checkbox"/> Neglect | <input type="checkbox"/> Institutional Abuse     |
| <input type="checkbox"/> Other (please specify) |                                  |  |

HAS THERE BEEN PREVIOUS CONCERN OR EVIDENCE OF ABUSE?\*

Yes  No  Don't know

If yes, what was the nature of the concern and the outcome?

\_\_\_\_\_  
 \*Please tick appropriate box/es

**ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES**



Outcome of Joint Agency Consultation\*

Single Agency Investigation by:

Social Services       Police       RQIA

Joint Investigation by:

Social Services       Police       RQIA

OR

Protocol for Joint Investigation of alleged and suspected cases of abuse of vulnerable adults

Please specify if any other follow up will take place.

\_\_\_\_\_  
\_\_\_\_\_

Signature of person completing form: \_\_\_\_\_

Print Name: \_\_\_\_\_

Designation: \_\_\_\_\_

Date: \_\_\_\_\_

- Please tick appropriate box/es

**ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES**

## Appendix 7

### ADULT PROTECTION: FORM AJP2 - STRATEGY FOR INVESTIGATION

Name of Vulnerable Adult: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_

(A) PEOPLE IN ATTENDANCE/INVOLVED (NAME & AGENCY):

\_\_\_\_\_  
\_\_\_\_\_

OTHERS CONSULTED:

\_\_\_\_\_  
\_\_\_\_\_

(B) INITIAL STRATEGY: Date: \_\_/\_\_/\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Next of Kin/Carer to be informed: YES/NO By Whom: \_\_\_\_\_

(i) Amendments to strategy

Date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone/Meeting\*  
Persons Involved/Designation:

\_\_\_\_\_  
\_\_\_\_\_

(ii) Amendments to strategy

Date:

(C) PERSONS TO BE INTERVIEWED

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone/Meeting\*  
Persons Involved/Designation:

\_\_\_\_\_  
\_\_\_\_\_

\* Please delete as appropriate

**ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES**

1 Person making the allegation to clarify all facts about referral

Name: \_\_\_\_\_

Address: \_\_\_\_\_

2 Next of kin or other carers:

Name: \_\_\_\_\_ Relationship to Vulnerable Adult: \_\_\_\_\_

Address: \_\_\_\_\_

3 Significant others  
(attach separate sheet if necessary)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date & Time: _____
Venue: _____
<b>Who will conduct?</b>
SW: _____
PSNI: _____
Other: _____

4 The Vulnerable Adult

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date & Time: _____
Venue: _____
<b>Who will conduct?</b>
SW: _____
PSNI: _____
Other: _____

5 The Alleged Perpetrator

Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Vulnerable Adult: \_\_\_\_\_

Date & Time: _____
Venue: _____
<b>Who will conduct?</b>
SW: _____
PSNI: _____
Other: _____

\* Please delete as appropriate

**ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES**



(D) Has a statement of complaint been made? YES/NO\*

By Whom: \_\_\_\_\_

Does the vulnerable adult have the capacity to:

(a) Consent to interview? YES/NO\*

b) Consent to medical examination? YES/NO\*

On what basis were these decisions made? \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Designation: \_\_\_\_\_

(of Person completing form)

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

\* Please delete as appropriate

**ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES**

## Appendix 8

### ADULT PROTECTION: FORM AJP3 - CLARIFICATION DISCUSSION

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Venue: \_\_\_\_\_

#### CONSIDERATIONS:

1 Has the adult previously made a clear disclosure of abuse or are there substantive grounds for suspecting abuse has occurred?

Comment: \_\_\_\_\_  
\_\_\_\_\_

2 Is the adult willing to engage in an interview?

Comment: \_\_\_\_\_  
\_\_\_\_\_

3 Is the adult able to engage in an interview?

Comment: \_\_\_\_\_  
\_\_\_\_\_

4 Has the purpose of the interview been explained to the adult?

Comment: \_\_\_\_\_  
\_\_\_\_\_

5 Which format is the most suitable for the interview? If a video interview appears to be the most appropriate option assess the adult's willingness to be interviewed on video.

Comment: \_\_\_\_\_  
\_\_\_\_\_

Decision: VIDEO                      STATEMENT                      QUESTION AND ANSWER

(Circle format to be used)





NATURE OF DISCUSSION:

CONTEMPORANEOUS, VERBATIM RECORD OF DISCLOSURE:

Multiple horizontal lines for recording the verbatim record of disclosure.

(Please close with diagonal line)

SIGNATURE OF PERSON MAKING NOTES: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

DESIGNATION: \_\_\_\_\_ DATE: \_\_\_\_\_

(NOTE: Responsibility for completion rests with either **Police or Social Services**)

The Protocol has been produced by the Health & Social Care Board in partnership with the Health & Social Care Trusts, Police Service of Northern Ireland and The Regulation and Quality Improvement Authority.

<b>TYPE OF DOCUMENT</b>	<input type="checkbox"/> Trust Policy for approval by Trust Policy Committee  <input type="checkbox"/> Patient based standard, guideline or policy for approval by Standards and Guidelines Committee
<b>TITLE</b>	<b>Prevention of Patient Falls</b>

<b>Summary</b>	Processes that will ensure that the risk of patients' falling is minimised.
<b>Purpose</b>	<ul style="list-style-type: none"> <li>• To educate staff on risk assessment procedures in order that they can identify patients at risk of falling.</li> <li>• To educate staff on preventative measures which can be taken to reduce the prevalence of falls.</li> <li>• To raise awareness of possible contributing factors.</li> <li>• To inform patients and carers of the risk of falls and what can be done to reduce the risk.</li> </ul>
<b>Operational date</b>	October 2009
<b>Review date</b>	October 2010
<b>Version Number</b>	V 1
<b>Supersedes previous</b>	
<b>Director Responsible</b>	Mrs Nicki Patterson, Acting Director of Nursing
<b>Lead Author</b>	Mrs Mary McElroy
<b>Lead Author, Position</b>	Senior Manager Nursing
<b>Additional Author(s)</b>	Olive Macleod
<b>Department / Service Group</b>	Nursing
<b>Contact details</b>	<i>Administration Building, Knockbracken, Telephone: 02890960089</i>

<b>Reference Number</b>	SG045/09
<b>Supercedes</b>	Legacy Trust Prevention of Patient Falls Policies

**Standards & Guidelines Committee – Prevention of patient falls – V1 – October 2009**

<b>Date</b>	<b>Version</b>	<b>Author</b>	<b>Comments</b>
February 08	V0.1	Mary McElroy	First Draft
March 09	V0.2	Mary McElroy	Second Draft
June 09	V0.3	Mary McElroy	Third Draft – changes to tool in light of incident. Sent to service groups and users for comment.
October 2009	V0.4	Mary McElroy	Final version

### **Policy Record**

		<b>Date</b>	<b>Version</b>
Author (s)	Approval	Feb 2008	V0.1
Director Responsible	Approval	Feb 2008	V0.1

### **Approval Process – Trust Policies**

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

### **Approval Process – Clinical Standards and Guidelines**

Standards and Guidelines Committee	Approval	25/06/09	V1
Policy Committee	Approval	12/10/09	V1
Executive Team	Authorise	14/10/09	V1
Appropriate Director	Sign Off	20/10/09	V1

**Full Description**

<b>Reference No:</b>	SG 045/09
<b>1</b>	<b>Title: Prevention of patient falls</b>
	<b>Introduction</b> Falls are one of the most commonly reported adverse incidents in the Trust This policy recognises the need to guarantee that everything is done to ensure the risks of patients falling is reduced and that harm is minimised without compromising the patients' independence.
<b>3</b>	<b>Purpose:</b> <ul style="list-style-type: none"> <li>• To educate staff on risk assessment procedures in order that they can identify patients at risk of falling.</li> <li>• To educate staff on preventative measures which can be taken to reduce the prevalence of falls.</li> <li>• To raise awareness of possible contributing factors.</li> <li>• To inform patients and carers of the risk of falls and what can be done to reduce the risk.</li> </ul>
<b>4</b>	<b>The scope:</b> This policy will apply to all Trust facilities.
<b>5</b>	<b>Objectives:</b> To ensure that each service group adhere to this policy including the use of the risk assessment screening document (appendix 1), thus ensuring patients safety at all times
<b>6</b>	<b>Roles and Responsibilities:</b> It is the responsibility of all trust employees to adhere to this policy
<b>7</b>	<b>The definition and background of the policy:</b> Patient falls are a serious and common problem among the general population. There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries that may be sustained are not trivial. However, there is much that can be done to reduce the risk of falls and minimise harm, whilst at the same time properly allowing patients freedom and mobilisation during their stay in hospital.
<b>8</b>	<b>Policy statements:</b>
<b>8.1</b>	A falls assessment should be carried out on each patient on admission (appendix 1)
<b>8.2</b>	All preventative measures should be put in place for identified at risk patients as per relevant identified action plan

8.3	Where appropriate bed rails assessment must be completed (Appendix 2).
8.4	All at risk patients should have a care plan developed, implemented and evaluated on an ongoing basis with referral made to appropriate member(s) of Multi-disciplinary Team.
8.5	Following admission all patients should be made familiar with the ward as soon as possible e.g. call bell system, whereabouts of toilets etc.
8.6	Environment around bed should be made safe at all times taking into consideration patients requirement for lighting, mobility aids, items of personal care and safe access to bed, chair and locker
8.7	Potential hazards to mobility should be reduced including use of no/ inappropriate walking aids; ill-fitting footwear and trailing clothing
8.8	Bed height should be kept at lowest position except during direct patient care
8.9	Where clinically possible, beds should be positioned so that confused patients are nursed close to the nursing station and patients requiring frequent toileting, are close to the bathroom
8.10	Relatives/ next of kin should be informed of any patient identified as high risk of falling and advised to ensure a safe environment is maintained during visiting and on immediately on leaving
8.11	Staff should be vigilant at all times to any potential hazards such as spills.
8.12	Appropriate signage should be used to warn people of hazards.
8.13	Equipment should be positioned to ensure cabling does not cross pedestrian routes.
8.14	All falls should be recorded immediately within nursing documentation and on an IR1 form.
8.15	Relatives/next of kin should be informed of any patient falls as soon as is practicable.
	<p><b>Source(s) / Evidence Base:</b>  Legacy Trust Policies.  Northern Ireland Regional Falls Project 2003  Chartered Society of Physiotherapists, the British Association of Occupational Therapists, the British Geriatric Society, The Royal College of Physicians, the Royal College of Nursing and Age Concern:- 'The Collaborative Rehabilitative Management of Elderly Patients who Fall.'  National Services Framework for Older People. Standard 6 – Falls, NSF England, 2001</p>
	<p><b>References, including relevant external guidelines:</b>  National Patient Safety Agency 3<sup>rd</sup> Report (2007) Slips, Trips and Falls in Hospital  DOH (2001) The National Service Framework for Older People.</p>

	<p>DOH (2006) Health Technical Memorandum 61: Flooring                  National Institute for Clinical Excellence (2004) Falls: The Assessment and Prevention of Falls in Older People.                  Royal College of Physicians, National Audit of the Organisation of Services For Falls and Bone Health for Older People, Jan 2006                  Simpson JM, Harrington R and Marsh N, 'Guidelines for managing falls among elderly people', Physiotherapy, 1998, Vol 84, No 4, 173-177.</p>
	<p><b>Consultation Process:</b>                  Trust Service Group Directors, Staff Side &amp; Policy Committee.</p>
	<p><b>Equality and Human Rights screening carried out:</b>                  In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.</p> <p>√ Screening completed                  No action required.</p>

\_\_\_\_\_  
**Chief Executive / Director**  
*(Delete as appropriate)*

**Date:**

\_\_\_\_\_  
**Author**

**Date:**

## Appendix one

### Falls Risk Assessment Screening Tool

#### ! Summary

- Use this screening tool to identify the patient/client's risk rating
- This form can be photocopied as a blank risk assessment form

Clients Name:  
Address

ID No  
Cons/G.P.  
Location

DOB:

Assessment Criteria		Score	Date (circle score)	Date (circle score)	Date (circle score)
Age	86+ 81-85 65-80	3 2 1			
Gender	Female Male	3 1			
History of Falls	Recurrent Falls in last 12 months Fall in Last 12 months Fall more than 12 months ago Never Fallen	3 2 1 0			
Present Level of Mobility	Assistance of 1+ or – Aid Assistance of 2+ or – Aid Independent with walking aid Independent and safe Unaided Immobile/Hoist	3 2 1 0 0			
Balance	Can Patient Stand Unsupported? No Yes	3 0			
Activities of Daily Living	Personal – Requires Assistance Independent with equipment Independent and safe Domestic – Requires Assistance Independent with equipment Independent and Safe	2 1 0 2 1 0			
Footwear	Unsafe Safe	3 0			
Patient's Vision	Visual Problems Identified Yes No	3 0			
Bladder & Bowel Management	Frequency Identified Problems No identified problems	3 2 0			
Potential Environmental Hazards	Yes No	3 0			
Social Risks	Living Alone Residential /Intermittent Support 24 Hour Care (either Nursing or Family)	3 2 1			



**Falls Risk Assessment Screening Tool Page 1 of 2**

Assessment Criteria		Score	Date (circle score)	Date (circle score)	Date (circle score)
<b>Medical Condition</b>	Neurological Problem Identified	2	<b>3</b>	<b>3</b>	<b>3</b>
	Postural Hypotension	2	<b>2</b>	<b>2</b>	<b>2</b>
	Cardiac Conditions	2	<b>1</b>	<b>1</b>	<b>1</b>
	Major Musculoskeletal	2	<b>0</b>	<b>0</b>	<b>0</b>
	Previous/Current Fracture	2			
	Listed Conditions	1			
	Other/No identified Medical Condition <b>(max score in this category is 3)</b>	0			
<b>Medications</b>	4 or more Medications	<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>
	Less than 4 Medications	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>
	No Medications	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Safety Awareness</b>	Insight into Personal Safety	<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>
	No Yes	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Mental State</b>	Confused	<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>
	Orientated	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total Score (max score of 46)</b>			<b>Total</b>	<b>Total</b>	<b>Total</b>
1 <sup>st</sup> Assessment Print Name	2nd Assessment Print Name	3rd Assessment Print Name	Signature	Signature	Signature
Designation	Designation	Designation			

Risk Categories		Date of Intervention/Referral	Date of Intervention/Referral	Date of Intervention/Referral
<b>Low Risk (3-17)</b>	Advice Leaflets Provided			
	Refer to appropriate services e.g. Physiotherapy/O.T			
<b>Medium Risk (18-23)</b>	Comprehensive falls assessment and address problems identified			
	Refer to appropriate services e.g. Physiotherapy/O.T			
	Advice Leaflets Provided			
	Monitor and Review			
<b>High Risk (24-46)</b>	Comprehensive falls assessment and address problems identified			
	Refer to appropriate services e.g. Physiotherapy/O.T			
	Highlight risk to staff/carers/family/patient /client			
	Advice Leaflets Provided			
	Consider use of hip protectors/alarm devices			
	Monitor and Review			
<b>Comments</b>				

## Falls Risk Assessment Screening Tool Page 2 of 2

### Appendix 2 Nursing Action to be taken to Minimise Risk of Patient Falls

Nursing Actions For All Patients	Date & Initials	Nursing Actions Additional actions for at Risk Patients	Date & Initials
Introduce and orientate patient to environment and routine e.g. Meal times.		Position patient's bed close to bathroom and nurses station	
Instruct patient in use of nurse call system		Assist and supervise patient to bathroom and initiate regular toilet regime.	
Assess lighting level and the need for a night light.		Record patient's lying and standing blood pressure	
Ensure patients are able to reach ALL items they may need e.g. Glasses, walking aids etc.		Inform medical staff of falls risk score and document in patients clinical notes.	
Ensure area is free from obstacles and other hazards		Discuss patient's management with multidisciplinary team and document	
Frequently re-orientate to surroundings and routines		Discuss patient's risk and management with family/carer and document	
Check clothing is not causing a hazard and footwear is well fitting		Refer to physio and occupational therapy and document.	
Ensure bed is at the right height for the patient.			
Ensure chair is appropriate for the patient height and seating area.			
Provide information leaflet to patient and relatives			
Assess need for supervision to toilet/bathroom			
Carry out bedrails assessment			
REFER TO Physio and Occupational therapy and document			

## Appendix 3

### **GUIDANCE FOR STAFF - MEDICINES THAT MAY BE ASSOCIATED WITH AN INCREASED RISK OF FALLS**

A number of chronic diseases are associated with a higher risk of falling as are several classes of drugs. Recognising high risk medicines and limiting the use of these agents in patients at higher risk of a fall may significantly reduce associated falls. It is therefore important when patients are admitted to hospital to assess their medications, their concordance and also determine underlying diseases in order to gauge their risk of falling.

When assessing a patient try to ascertain if the patient requires help getting a regular supply of medicines or needs help opening containers. These factors may influence their concordance, which may have an effect on their disease. This in turn could increase their chance of falling. When taking a drug history, ascertain if the patient is purchasing any medicines from a Pharmacy or supermarket including herbal or homeopathic remedies. These may have an influence on the risk of a fall or potentially interact with their prescribed medication. If a patient is taking more than four medicines they are considered at higher risk of falling. Other physical factors to look for to determine concordance to medicines are ability to swallow medicines, the patient's vision or hearing, their mobility, their memory and their ability to follow instructions. If any of the above are a concern, look at the medicines in combination with these factors to determine if the patient will be at high risk of falling.

Chronic diseases that have been associated with falls include arthritis, cardiovascular disease, COPD, depression and diabetes. These are just a few examples so it is always important to look at current medication along with the underlying disease. Medications are commonly implicated as causative factors in falls and the examples below will help highlight those that may be associated with a high risk.

#### **Benzodiazepines**

Long acting benzodiazepines have extremely long half lives in the elderly (often days) producing sedation and impaired balance therefore increasing the incidence of falls and fractures. Long acting benzodiazepines include diazepam, alprazolam, chlordiazepoxide and clobazam. All other benzodiazepines may still cause sedation and therefore put certain groups of patients at higher risk.

#### **Other Hypnotics and Anxiolytics**

These include zaleplon, zolpidem and zopiclone. Also some antihistamines are used for their sedative qualities, eg. Diphenhydramine or promethazine.

#### **Analgesics**

Many of these cause sedation and drowsiness as a side effect. Co-proxamol should be avoided altogether in the elderly. Other analgesics include co-codamol, co-dydramol, nefopam, tramadol, dihydrocodeine, codeine, morphine and other opioid analgesics.

### **Antiepileptics**

These may all cause sedation increasing the risk of a fall. Examples of this type of drug include carbamazepine, gabapentin, lamotrigine and phenytoin.

### **Antiparkinson drugs**

When initiating co-careldopa or co-beneldopa excessive daytime sleepiness may occur. Patients should be monitored closely when starting these medicines. Other antiparkinson drugs may cause sedation. Examples include amantadine, entacapone, pramipexole, selegiline or procyclidine.

### **Tricyclic Antidepressants**

These have anticholinergic and sedating properties. These include amitriptyline, doxepin, dosulepin or lofepramine.

### **Oral Hypoglycaemics**

These are used in diabetes. Chlorpropamide and glibenclamide should be avoided in the elderly as they have a prolonged half life. This may lead to prolonged and serious hypoglycaemia. Also chlorpropamide can cause syndrome of inappropriate secretion of antidiuretic hormone.

### **Antipsychotics**

All antipsychotics may cause sedation. Clozapine, chlorpromazine and thioridazine may lower the seizure threshold. Other examples of antipsychotics include haloperidol, levomepromazine, pimozide, aripiprazole, olanzapine or quetiapine. There are many others not listed.

### **Cardiovascular Drugs**

There are many classes of cardiovascular drugs which are considered to be high risk medicines for inducing falls. The most common reason for falling whilst taking these medicines is hypotension.

1. Betablockers including bisoprolol, metoprolol, carvedilol or sotalol.
2. ACE inhibitors, eg. Captopril, ramipril or perindopril.
3. Calcium Channel Blockers eg. Amlodipine, diltiazem or verapamil.
4. Nitrates eg. Isosorbide mononitrate or glyceryl trinitrate.
5. Diuretics which can lead to dehydration and therefore a fall in blood pressure. Electrolyte fluxes and urinary incontinence can also occur as a side effect. Examples include frusemide, bumetanide or spironolactone.
6. Always monitor digoxin as toxic effects may lead to dizziness amongst other side effects.

### **Steroids**

These are used in a number of chronic diseases including asthma, COPD or cancer. They put the patient at increased risk of fractures if they fall, so falling could potentially be harmful to patient. Examples of steroids are prednisolone or dexamethasone.

### **Herbal Medicines**

A number of herbal medicines by their action may cause drowsiness, the most common being Valerian, Jamaican Dogwood and passiflora. These are contained in many herbal remedies bought from a pharmacy or supermarket for stress or to aid sleep. If ingredients of a herbal remedy are unknown, contact pharmacy for further information.

### **Alcohol**

This causes sedation.

***The above lists give an idea of some of the medicines that may need to be revised or monitored if a patient is admitted to hospital. This list is not exhaustive so it is important to use your judgement or contact pharmacy for further advice.***

**Appendix 4****BELFAST HEALTH & SOCIAL CARE TRUST****Prevention of falls in hospital****What this leaflet is about**

Falls in hospital are the most commonly reported patient accident. People may fall in hospital for a variety of reasons. These include general weakness or ongoing balance problems, sudden changes in health leading to hospital admission, disorientation due to unfamiliar surroundings, the effects of newly prescribed medications, and slipping due to vinyl floors.

By raising awareness of what may cause a fall and giving information on how to reduce or eliminate the risk Belfast Health & Social Care Trust aims to reduce the number of falls that occur in hospital.

**What we are doing to prevent falls**

Falls cannot always be prevented but by assessing the risks we aim to reduce the number of falls in hospital. Training is provided for staff to be aware of risks in the environment. This may include hazards such as slippery or cluttered floors and trailing leads on equipment. Many risks are related to a person's age and ability. Nursing staff will assess the patient's needs on admission. These needs may change, for example, if a person becomes confused or disorientated. Important safety issues are documented in the patient's plan of care. Nursing staff are trained in the use of moving and handling equipment and will follow the advice of physiotherapists regarding the patient's mobility. All wards will display notices which raise awareness of safety issues in that particular area.

**What you can do to help prevent falls**

A safe environment reduces the risk of falling for everyone on the ward; patients, visitors and staff. To help us maintain a safe environment you can;

- **Keep floor spaces clear** – equipment, boxes and belongings on the floor are a trip hazard. Try to keep your bed-space tidy. Use the storage provided and put away items that are not being used.
- **Be aware of wet floors** – areas such as kitchens and bathrooms are prone to spills. If you spot a wet area let staff know immediately. Do not clean up unknown substances as there may be an infection risk. Areas that are being cleaned will display warning notices and extra care should be taken around here if the area can not be avoided.
- **Follow ward guidelines on use of equipment** – Make sure that you have any walking aids with you in hospital and that you have your hearing aid or spectacles to hand if you need them. Keep everything you need within easy reach and leave the call bell where you can reach it. Avoid stretching or bending to reach things Do not use equipment (and alert staff) if broken.
- **Be aware of good Lighting** - Make sure you have sufficient lighting during the day and night.
- **Use own equipment safely** - your own equipment, are used at your own risk as they have not been received hospital safety checks.
- **Use moving and handling aids correctly** - if you have been given an aid to assist you move around the ward or bed, e.g. frame, wheelchair or bed-blocks, ensure that you are using these as they have been shown. Do not use furniture, such as tables, to help with standing up.

- **Be aware of 'attached' equipment** - this may include leads for monitoring equipment or drips and drains which present a trip hazard for you or you relatives/visitors. If equipment cannot be detached, get nursing support when moving it. Use the nurse call bell for assistance if you feel weak or dizzy
- **Get up from your bed or chair slowly** Remember that blood pressure falls as you stand up and in older people the body may take longer to adjust

### **What to do if a fall does happen**

If a fall does occur, whether a patient or visitor, you should inform nursing staff **IMMEDIATELY**. They will make the area safe and attend the person who has fallen. With your consent we will inform your next of kin and record the incident in your medical notes as well as recording it on our incident reporting system.

Patients will be checked by the ward doctor, visitors should attend Accident and Emergency Department to be checked and receive any treatment.

The incident form is looked at by in health and safety and risk managers and aims to prevent reoccurrence by identifying and removing the risk(s). It is important that 'near-misses' are also reported as the risk remains the same.

### **Being Safety Aware**

Being aware of the risks is the best way to help reduce falls. If you spot a potential risk on the ward you should inform a member of staff immediately.

### **Advice for carers, relatives and Friends**

For the safety of patients, it would help us greatly if you would report to staff any possible problems in the ward such as:-

- Spills of liquid on the floor
- Trailing wires/cables
- Obstacles around the bed area

### **We would also ask that you: -**

- Leave the patient's room/bed space tidy by replacing your chairs
- Take unnecessary items home to reduce bedside clutter
- Replace bed tables and call bells moved during your visit





<b>TYPE OF DOCUMENT</b>	<input type="checkbox"/> Trust Policy for approval by Trust Policy Committee <input type="checkbox"/> Patient based standard, guideline or policy for approval by Standards and Guidelines Committee
<b>Prevention of Patient Falls</b>	
<b>Summary</b>	Processes that will ensure that the risk of patients' falling is minimised.
<b>Purpose</b>	<ul style="list-style-type: none"> <li>• To educate staff on risk assessment procedures in order that they can identify patients at risk of falling.</li> <li>• To educate staff on preventative measures which can be taken to reduce the prevalence of falls.</li> <li>• To raise awareness of possible contributing factors.</li> <li>• To inform patients and carers of the risk of falls and what can be done to reduce the risk.</li> </ul>
<b>Operational date</b>	October 2009
<b>Review date</b>	March 2014
<b>Version Number</b>	V2
<b>Director Responsible</b>	Ms Brenda Creaney, Director of Nursing
<b>Lead Author</b>	Mrs Mary McElroy
<b>Lead Author, Position</b>	Senior Manager Nursing
<b>Additional Author(s)</b>	Olive Macleod
<b>Department / Service Group</b>	Nursing
<b>Contact details</b>	<i>Administration Building, Knockbracken, Telephone: 02890960089</i>

<b>Reference Number</b>	SG045/09
<b>Supercedes</b>	Legacy Trust Prevention of Patient Falls Policies

Date	Version	Author	Comments
February 08	V0.1	Mary McElroy	First Draft
March 09	V0.2	Mary McElroy	Second Draft
June 09	V0.3	Mary McElroy	Third Draft – changes to tool in light of incident. Sent to service groups and users for comment.
October 2009	V0.4	Mary McElroy	Final version
March 2011	V2	Olive MacLeod	Review of policy – change of date only

#### Policy Record

		Date	Version
Author (s)	Approval	Feb 2008	V0.1
Director Responsible	Approval	Feb 2008	V0.1

#### Approval Process – Trust Policies

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

#### Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval	25/06/09	V1
Policy Committee	Approval	12/10/09	V1
Executive Team	Authorise	14/10/09	V1
Appropriate Director	Sign Off	20/10/09	V1

**Full Description**

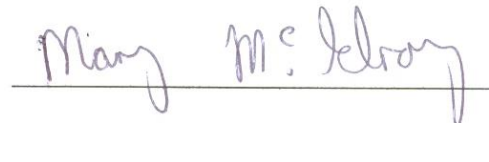
<b>Reference No:</b>	SG 045/09
<b>1</b>	<b>Title: Prevention of patient falls</b>
	<b>Introduction</b> Falls are one of the most commonly reported adverse incidents in the Trust This policy recognises the need to guarantee that everything is done to ensure the risks of patients falling is reduced and that harm is minimised without compromising the patients' independence.
<b>3</b>	<b>Purpose:</b> <ul style="list-style-type: none"> <li>• To educate staff on risk assessment procedures in order that they can identify patients at risk of falling.</li> <li>• To educate staff on preventative measures which can be taken to reduce the prevalence of falls.</li> <li>• To raise awareness of possible contributing factors.</li> <li>• To inform patients and carers of the risk of falls and what can be done to reduce the risk.</li> </ul>
<b>4</b>	<b>The scope:</b> This policy will apply to all Trust facilities.
<b>5</b>	<b>Objectives:</b> To ensure that each service group adhere to this policy including the use of the risk assessment screening document (appendix 1), thus ensuring patients safety at all times
<b>6</b>	<b>Roles and Responsibilities:</b> It is the responsibility of all trust employees to adhere to this policy
<b>7</b>	<b>The definition and background of the policy:</b> Patient falls are a serious and common problem among the general population. There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries that may be sustained are not trivial. However, there is much that can be done to reduce the risk of falls and minimise harm, whilst at the same time properly allowing patients freedom and mobilisation during their stay in hospital.
<b>8</b>	<b>Policy statements:</b>
<b>8.1</b>	A falls assessment should be carried out on each patient on admission (appendix 1)
<b>8.2</b>	All preventative measures should be put in place for identified at risk patients as per relevant identified action plan

8.3	Where appropriate bed rails assessment must be completed (Appendix 2).
8.4	All at risk patients should have a care plan developed, implemented and evaluated on an ongoing basis with referral made to appropriate member(s) of Multi-disciplinary Team.
8.5	Following admission all patients should be made familiar with the ward as soon as possible e.g. call bell system, whereabouts of toilets etc.
8.6	Environment around bed should be made safe at all times taking into consideration patients requirement for lighting, mobility aids, items of personal care and safe access to bed, chair and locker
8.7	Potential hazards to mobility should be reduced including use of no/ inappropriate walking aids; ill-fitting footwear and trailing clothing
8.8	Bed height should be kept at lowest position except during direct patient care
8.9	Where clinically possible, beds should be positioned so that confused patients are nursed close to the nursing station and patients requiring frequent toileting, are close to the bathroom
8.10	Relatives/ next of kin should be informed of any patient identified as high risk of falling and advised to ensure a safe environment is maintained during visiting and on immediately on leaving
8.11	Staff should be vigilant at all times to any potential hazards such as spills.
8.12	Appropriate signage should be used to warn people of hazards.
8.13	Equipment should be positioned to ensure cabling does not cross pedestrian routes.
8.14	All falls should be recorded immediately within nursing documentation and on an IR1 form.
8.15	Relatives/next of kin should be informed of any patient falls as soon as is practicable.
	<b>Source(s) / Evidence Base:</b> Legacy Trust Policies. Northern Ireland Regional Falls Project 2003 Chartered Society of Physiotherapists, the British Association of Occupational Therapists, the British Geriatric Society, The Royal College of Physicians, the Royal College of Nursing and Age Concern:- 'The Collaborative Rehabilitative Management of Elderly Patients who Fall.' National Services Framework for Older People. Standard 6 – Falls, NSF England, 2001
	<b>References, including relevant external guidelines:</b>
	National Patient Safety Agency 3 <sup>rd</sup> Report (2007) Slips, Trips and Falls in Hospital DOH (2001) The National Service Framework for Older People. DOH (2006) Health Technical Memorandum 61: Flooring

	<p>National Institute for Clinical Excellence (2004) Falls: The Assessment and Prevention of Falls in Older People.                  Royal College of Physicians, National Audit of the Organisation of Services For Falls and Bone Health for Older People, Jan 2006                  Simpson JM, Harrington R and Marsh N, 'Guidelines for managing falls among elderly people', Physiotherapy, 1998, Vol 84, No 4, 173-177.</p>
	<p><b>Consultation Process:</b>                  Trust Service Group Directors, Staff Side &amp; Policy Committee.</p>
	<p><b>Equality and Human Rights screening carried out:</b>                  In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.                  ✓ Screening completed                  No action required.</p>



**Director**



**Appendix one**

**Falls Risk Assessment Screening Tool**

**! Summary**

- Use this screening tool to identify the patient/client's risk rating
- This form can be photocopied as a blank risk assessment form

Clients Name:  
Address

ID No    DOB:  
Cons/G.P.  
Location

Assessment Criteria		Score	Date (circle score)	Date (circle score)	Date (circle score)
Age	86+ 81-85 65-80	3 2 1			
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History of Falls	Recurrent Falls in last 12 months Fall in Last 12 months Fall more than 12 months ago Never Fallen	3 2 1 0			
Present Level of Mobility	Assistance of 1+ or – Aid Assistance of 2+ or – Aid Independent with walking aid Independent and safe Unaided Immobile/Hoist	3 2 1 0 0			
Balance	Can Patient Stand Unsupported? No Yes	3 0			
Activities of Daily Living	Personal – Requires Assistance Independent with equipment Independent and safe	2 1 0			
	Domestic – Requires Assistance Independent with equipment Independent and Safe	2 1 0			
Footwear	Unsafe Safe	3 0			
Patient's Vision	Visual Problems Identified Yes No	3 0			
Bladder & Bowel Management	Frequency Identified Problems No identified problems	3 2 0			
Potential Environmental Hazards	Yes No	3 0 <b>Specify location</b>			
Social Risks	Living Alone Residential /Intermittent Support 24 Hour Care (either Nursing or Family)	3 2 1			

**Falls Risk Assessment Screening Tool Page 1 of 2**

Assessment Criteria			Score	Date (circle score)	Date (circle score)	Date (circle score)
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	Cardiac Conditions		2	<b>1</b>	<b>1</b>	<b>1</b>
	Major Musculoskeletal		2	<b>0</b>	<b>0</b>	<b>0</b>
	Previous/Current Fracture		2			
	Listed Conditions		1			
	Other/No identified Medical Condition <b>(max score in this category is 3)</b>		0			
<b>Medications</b>	4 or more Medications		<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>
	Less than 4 Medications		<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>
	No Medications		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Safety Awareness</b>	Insight into Personal Safety		<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>
	No Yes		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Mental State</b>	Confused		<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>
	Orientated		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total Score (max score of 46)</b>				<b>Total</b>	<b>Total</b>	<b>Total</b>
1 <sup>st</sup> Assessment Print Name	2 <sup>nd</sup> Assessment Print Name	3 <sup>rd</sup> Assessment Print Name		<b>Signature</b>	<b>Signature</b>	<b>Signature</b>
Designation	Designation	Designation				

Risk Categories		Date of Intervention/Referral	Date of Intervention/Referral	Date of Intervention/Referral
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	Highlight risk to staff/carers/family/patient /client			
	Advice Leaflets Provided			
	Consider use of hip protectors/alarm devices			
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<b>Comments</b>				



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## Appendix 2 Nursing Action to be taken to Minimise Risk of Patient Falls

Nursing Actions For All Patients	Date & Initials	Nursing Actions Additional actions for at Risk Patients	Date & Initials
Introduce and orientate patient to environment and routine e.g. Meal times.		Position patient's bed close to bathroom and nurses station	
Instruct patient in use of nurse call system		Assist and supervise patient to bathroom and initiate regular toilet regime.	
Assess lighting level and the need for a night light.		Record patient's lying and standing blood pressure	
Ensure patients are able to reach ALL items they may need e.g. Glasses, walking aids etc.		Inform medical staff of falls risk score and document in patients clinical notes.	
Ensure area is free from obstacles and other hazards		Discuss patient's management with multidisciplinary team and document	
Frequently re-orientate to surroundings and routines		Discuss patient's risk and management with family/carer and document	
Check clothing is not causing a hazard and footwear is well fitting		Refer to physio and occupational therapy and document.	
Ensure bed is at the right height for the patient.			
Ensure chair is appropriate for the patient height and seating area.			
Provide information leaflet to patient and relatives			
Assess need for supervision to toilet/bathroom			
Carry out bedrails assessment			
REFER TO Physio and Occupational therapy and document			

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A number of chronic diseases are associated with a higher risk of falling as are several classes of drugs. Recognising high risk medicines and limiting the use of these agents in patients at higher risk of a fall may significantly reduce associated falls. It is therefore important when patients are admitted to hospital to assess their medications, their concordance and also determine underlying diseases in order to gauge their risk of falling.

When assessing a patient try to ascertain if the patient requires help getting a regular supply of medicines or needs help opening containers. These factors may influence their concordance, which may have an effect on their disease. This in turn could increase their chance of falling. When taking a drug history, ascertain if the patient is purchasing any medicines from a Pharmacy or supermarket including herbal or homeopathic remedies. These may have an influence on the risk of a fall or potentially interact with their prescribed medication. If a patient is taking more than four medicines they are considered at higher risk of falling. Other physical factors to look for to determine concordance to medicines are ability to swallow medicines, the patient's vision or hearing, their mobility, their memory and their ability to follow instructions. If any of the above are a concern, look at the medicines in combination with these factors to determine if the patient will be at high risk of falling.

Chronic diseases that have been associated with falls include arthritis, cardiovascular disease, COPD, depression and diabetes. These are just a few examples so it is always important to look at current medication along with the underlying disease. Medications are commonly implicated as causative factors in falls and the examples below will help highlight those that may be associated with a high risk.

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Long acting benzodiazepines have extremely long half lives in the elderly (often days) producing sedation and impaired balance therefore increasing the incidence of falls and fractures. Long acting benzodiazepines include diazepam, alprazolam, chlordiazepoxide and clobazam. All other benzodiazepines may still cause sedation and therefore put certain groups of patients at higher risk.

#### **Other Hypnotics and Anxiolytics**

These include zaleplon, zolpidem and zopiclone. Also some antihistamines are used for their sedative qualities, eg. Diphenhydramine or promethazine.

#### **Analgesics**

Many of these cause sedation and drowsiness as a side effect. Co-proxamol should be avoided altogether in the elderly. Other analgesics include co-codamol, co-dydramol, nefopam, tramadol, dihydrocodeine, codeine, morphine and other opioid analgesics.

### **Antiepileptics**

These may all cause sedation increasing the risk of a fall. Examples of this type of drug include carbamazepine, gabapentin, lamotrigine and phenytoin.

### **Antiparkinson drugs**

When initiating co-careldopa or co-beneldopa excessive daytime sleepiness may occur. Patients should be monitored closely when starting these medicines. Other antiparkinson drugs may cause sedation. Examples include amantadine, entacapone, pramipexole, selegiline or procyclidine.

### **Tricyclic Antidepressants**

These have anticholinergic and sedating properties. These include amitriptyline, doxepin, dosulepin or lofepramine.

### **Oral Hypoglycaemics**

These are used in diabetes. Chlorpropamide and glibenclamide should be avoided in the elderly as they have a prolonged half life. This may lead to prolonged and serious hypoglycaemia. Also chlorpropamide can cause syndrome of inappropriate secretion of antidiuretic hormone.

### **Antipsychotics**

All antipsychotics may cause sedation. Clozapine, chlorpromazine and thioridazine may lower the seizure threshold. Other examples of antipsychotics include haloperidol, levomepromazine, pimozide, aripiprazole, olanzapine or quetiapine. There are many others not listed.

### **Cardiovascular Drugs**

There are many classes of cardiovascular drugs which are considered to be high risk medicines for inducing falls. The most common reason for falling whilst taking these medicines is hypotension.

1. Betablockers including bisoprolol, metoprolol, carvedilol or sotalol.
2. ACE inhibitors, eg. Captopril, ramipril or perindopril.
3. Calcium Channel Blockers eg. Amlodipine, diltiazem or verapamil.
4. Nitrates eg. Isosorbide mononitrate or glyceryl trinitrate.
5. Diuretics which can lead to dehydration and therefore a fall in blood pressure. Electrolyte fluxes and urinary incontinence can also occur as a side effect. Examples include frusemide, bumetanide or spironolactone.
6. Always monitor digoxin as toxic effects may lead to dizziness amongst other side effects.

### **Steroids**

These are used in a number of chronic diseases including asthma, COPD or cancer. They put the patient at increased risk of fractures if they fall, so falling could potentially be harmful to patient. Examples of steroids are prednisolone or dexamethasone.

### **Herbal Medicines**

A number of herbal medicines by their action may cause drowsiness, the most common being Valerian, Jamaican Dogwood and passiflora. These are contained in many herbal remedies bought from a pharmacy or supermarket for stress or to aid sleep. If ingredients of a herbal remedy are unknown, contact pharmacy for further information.

### **Alcohol**

This causes sedation.

***The above lists give an idea of some of the medicines that may need to be revised or monitored if a patient is admitted to hospital. This list is not exhaustive so it is important to use your judgement or contact pharmacy for further advice.***

**Appendix 4****BELFAST HEALTH & SOCIAL CARE TRUST****Prevention of falls in hospital****What this leaflet is about**

Falls in hospital are the most commonly reported patient accident. People may fall in hospital for a variety of reasons. These include general weakness or ongoing balance problems, sudden changes in health leading to hospital admission, disorientation due to unfamiliar surroundings, the effects of newly prescribed medications, and slipping due to vinyl floors.

By raising awareness of what may cause a fall and giving information on how to reduce or eliminate the risk Belfast Health & Social Care Trust aims to reduce the number of falls that occur in hospital.

**What we are doing to prevent falls**

Falls cannot always be prevented but by assessing the risks we aim to reduce the number of falls in hospital. Training is provided for staff to be aware of risks in the environment. This may include hazards such as slippery or cluttered floors and trailing leads on equipment. Many risks are related to a person's age and ability. Nursing staff will assess the patient's needs on admission. These needs may change, for example, if a person becomes confused or disorientated. Important safety issues are documented in the patient's plan of care. Nursing staff are trained in the use of moving and handling equipment and will follow the advice of physiotherapists regarding the patient's mobility. All wards will display notices which raise awareness of safety issues in that particular area.

**What you can do to help prevent falls**

A safe environment reduces the risk of falling for everyone on the ward; patients, visitors and staff. To help us maintain a safe environment you can;

- **Keep floor spaces clear** – equipment, boxes and belongings on the floor are a trip hazard. Try to keep your bed-space tidy. Use the storage provided and put away items that are not being used.
- **Be aware of wet floors** – areas such as kitchens and bathrooms are prone to spills. If you spot a wet area let staff know immediately. Do not clean up unknown substances as there may be an infection risk. Areas that are being cleaned will display warning notices and extra care should be taken around here if the area can not be avoided.
- **Follow ward guidelines on use of equipment** – Make sure that you have any walking aids with you in hospital and that you have your hearing aid or spectacles to hand if you need them. Keep everything you need within easy reach and leave the call bell where you can reach it. Avoid stretching or bending to reach things Do not use equipment (and alert staff) if broken.
- **Be aware of good Lighting** - Make sure you have sufficient lighting during the day and night.
- **Use own equipment safely** - your own equipment, are used at your own risk as they have not been received hospital safety checks.
- **Use moving and handling aids correctly** - if you have been given an aid to assist you move around the ward or bed, e.g. frame, wheelchair or bed-blocks, ensure that you are using these as they have been shown. Do not use furniture, such as tables, to help with standing up.

- **Be aware of 'attached' equipment** - this may include leads for monitoring equipment or drips and drains which present a trip hazard for you or your relatives/visitors. If equipment cannot be detached, get nursing support when moving it. Use the nurse call bell for assistance if you feel weak or dizzy
- **Get up from your bed or chair slowly** Remember that blood pressure falls as you stand up and in older people the body may take longer to adjust

### **What to do if a fall does happen**

If a fall does occur, whether a patient or visitor, you should inform nursing staff **IMMEDIATELY**. They will make the area safe and attend the person who has fallen. With your consent we will inform your next of kin and record the incident in your medical notes as well as recording it on our incident reporting system.

Patients will be checked by the ward doctor, visitors should attend Accident and Emergency Department to be checked and receive any treatment.

The incident form is looked at by health and safety and risk managers and aims to prevent reoccurrence by identifying and removing the risk(s). It is important that 'near-misses' are also reported as the risk remains the same.

### **Being Safety Aware**

Being aware of the risks is the best way to help reduce falls. If you spot a potential risk on the ward you should inform a member of staff immediately.

### **Advice for carers, relatives and Friends**

For the safety of patients, it would help us greatly if you would report to staff any possible problems in the ward such as:-

- Spills of liquid on the floor
- Trailing wires/cables
- Obstacles around the bed area

### **We would also ask that you: -**

- Leave the patient's room/bed space tidy by replacing your chairs
- Take unnecessary items home to reduce bedside clutter
- Replace bed tables and call bells moved during your visit



Northern  
Ireland  
Office



Department of  
**Health, Social Services  
and Public Safety**

[www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydënter Heisin  
an Fowk Siccar**

**ADULT SAFEGUARDING**

**IN**

**NORTHERN IRELAND**

**REGIONAL AND LOCAL**

**PARTNERSHIP ARRANGEMENTS**

March 2010

## ADULT SAFEGUARDING IN NORTHERN IRELAND REGIONAL AND LOCAL PARTNERSHIP ARRANGEMENTS

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## ADULT SAFEGUARDING IN NORTHERN IRELAND REGIONAL AND LOCAL PARTNERSHIP ARRANGEMENTS

### Introduction

1. This guidance is being issued in the context of a developing government policy framework which aims to improve safeguarding and protection outcomes for adults in Northern Ireland who are vulnerable. The development of the policy framework is being undertaken jointly by the Department of Health, Social Services and Public Safety (DHSSPS) and the Northern Ireland Office (NIO) with the support of other government departments.
2. Health and social care and criminal justice agencies have a lead role to play in preventing, detecting and providing protection to vulnerable adults. Specifically they seek to ensure that vulnerable adults receive protection, support and equitable access to the criminal justice system. However, a successful safeguarding agenda requires the support of a much wider network of agencies, organisations, bodies and communities of interest across the statutory, voluntary, community, private and faith sectors. Safeguarding involves not only high quality health and social care provision and responsive policing but also safer communities, coherent public transport policies, public health, housing, promotion of social inclusion, education and adult learning opportunities and effective preventative services. It also requires the support of families and carers and the general public, who, through general good neighbourliness and acts of citizenship, are also key to securing improved safeguarding outcomes for adults who are vulnerable. The overall aim is to move focus from objectives to outcomes as illustrated in **Appendix 1**.
3. The abuse of adults must be recognised for what it actually is. It is an assault on the human and civil rights of the abused individual and can have a significant impact on independence, health and social well-being. Our collective aim is to prevent the abuse of adults whose vulnerability heightens the risk of abuse. A rights-based, multi-disciplinary, interagency approach to adult safeguarding is essential with partner organisations and groups working together in a spirit of co-operation, openness and transparency. Each partner member must be clear about what is expected from it, what its obligations are and where its involvement ends.
4. Adult safeguarding and protection work must be conducted in a way which is person-centred, underpinned by human rights considerations and guided by the principles and approaches set out in *Safeguarding Vulnerable Adults*,<sup>1</sup> the Regional Adult Protection Policy & Procedural Guidance, published in

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<sup>1</sup> Safeguarding Vulnerable Adults can be accessed at:  
[http://www.nhssb.n-i.nhs.uk/publications/social\\_services/Safeguarding\\_Vulnerable\\_Adults.pdf](http://www.nhssb.n-i.nhs.uk/publications/social_services/Safeguarding_Vulnerable_Adults.pdf)

September 2006 and its associated Joint Protocol,<sup>2</sup> revised and published in July 2009.

5. For the purposes of this guidance and the outworking of the partnership arrangements it describes, the definition of vulnerable adult as set out in *Safeguarding Vulnerable Adults* will continue to apply. The definition is:
 

*“a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.”*
6. However, this definition will be subject to further consideration and potential revision as part of ongoing policy development work. It is important that adult protection investigations should at all times be conducted in accordance with *Safeguarding Vulnerable Adults* and the associated Joint Protocol.
7. While much learning can be derived from the experience of child protection and working with families, there are important differences in work related to safeguarding vulnerable adults. For example, there are considerations to be taken account of such as balancing safeguarding with the right to autonomy and self-determination, securing meaningful consent, assessing mental capacity and assessing and managing risk; adults may be subject to financial exploitation in addition to other forms of abuse; and a different approach is needed for carers, who are often partners, from that which is needed for parents. An important emphasis in adult safeguarding work is on empowerment which enables people, whose situation makes them vulnerable, to keep themselves safe. These are just some of the issues for consideration by the new Safeguarding Partnerships:
  - the regional body - the ***Northern Ireland Adult Safeguarding Partnership (NIASP)***; and
  - the local bodies - ***the five Local Adult Safeguarding Partnerships (LASPs)***.
8. In summary, the NIASP will determine the strategy for safeguarding vulnerable adults, develop and disseminate guidance and operational policies and procedures, monitor trends and outcomes and monitor and evaluate the effectiveness of partnership arrangements. In broad terms the LASPs will facilitate practice, including engagement with service users, families and carers and the wider public, at a local level. The roles and responsibilities of the NIASP and LASPs, the relationship between them and the mechanisms for

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<sup>2</sup> The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults can be accessed through: <http://www.hscboard.hscni.net/publications/index.html>

securing meaningful participation from service users and carers or their representative organisations, are set out in detail below.

## **THE NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)**

### **Role and Responsibilities**

9. The role of the NIASP is to develop a strategic approach to safeguarding vulnerable adults. Its specific responsibilities are:
  - a) to determine, in conjunction with LASPs, the strategy for safeguarding vulnerable adults, identify agreed objectives and priorities for its work, set out in a 3-5 year Strategic Safeguarding Plan for Northern Ireland. The Strategic Safeguarding Plan will be supported by annual Safeguarding Work Plans;
  - b) to promote activity that raises awareness of adult abuse and the need to safeguard adults at risk of abuse and which highlights the contribution that individuals, carers, families, communities and the wider public can make to safeguarding;
  - c) to seek continuous improvement in preventive and early intervention services and in services designed to support victims and their carers and families when abuse occurs;
  - d) to develop, agree, disseminate and keep under review guidance, operational policies and procedures for multi-disciplinary, interagency work to safeguard vulnerable adults, including time frames for action;
  - e) to improve outcomes for vulnerable adults by setting objectives, performance indicators and, where appropriate, establishing appropriate thresholds for intervention taking account of multi-professional, organisation and other contributions to safeguarding and the views of service users, families, carers and the wider public;
  - f) to ensure that equality of opportunity is central to the development of safeguarding policies and procedures and to guarantee that an equality perspective is incorporated in safeguarding policy at all levels and all stages;
  - g) to communicate clearly to partner organisations, individual services and professional groups and the wider public a shared responsibility for safeguarding vulnerable adults, and to explain how that responsibility can be fulfilled;

- h) to bring to the attention of each member organisation's board/executive body their responsibilities for safeguarding vulnerable adults and developments needed in the arena, including resource requirements or changes needed in practice or service provision, and how the NIASP Strategic Safeguarding Plan and annual Safeguarding Work Plans will address these;
- i) to monitor and evaluate on a regular and continuing basis how well services work individually and collectively to safeguard vulnerable adults and how well the partnerships are working;
- j) to ensure that each partner organisation has a clear, well-publicised policy of "Zero-Tolerance" of neglect, exploitation or abuse wherever they occur;
- k) to develop and secure delivery of an interagency/inter-disciplinary training and development strategy with the aim of improving the quality of safeguarding work and of interagency/inter-disciplinary working having identified the training needs of those involved in safeguarding work across Northern Ireland. The strategy should take account of how training partnerships with LASPs can be developed;
- l) to ensure that each partner organisation has effective training arrangements for its personnel ranging from awareness training for front line staff to the more in depth training required to discharge specialist functions;
- m) to develop and maintain strong links between NIASP and LASPs and equivalent child protection structures in Northern Ireland; and to:
  - facilitate better information sharing between them for the purposes of shared learning;
  - secure effective co-working where this is required; and
  - make sure that young people, particularly around the ages of 16 to 19, do not fall through gaps in processes and practice because of any uncertainty about which professionals and bodies have safeguarding responsibility, particularly if there is a safeguarding concern which lasts some time and covers the transition from children's to adult services;
- n) to ensure that there are strong and effective links between the NIASP and Multi-Agency Risk Assessment Conferences (MARAC); Public Protection Arrangements Northern Ireland (PPANI); the United Kingdom Human Trafficking Centre (UKHTC); and the United Kingdom Border Agency (UKBA);

- o) to forge effective links with bodies outside Northern Ireland that impact on the lives and well-being of vulnerable adults here, e.g. the approach to track and manage sex offenders in the Republic of Ireland;
- p) to properly integrate adult safeguarding strategies with other relevant strategies and procedures, e.g. child protection; domestic violence; sexual violence and abuse; human trafficking; and the assessment and management of individuals who may be a risk to themselves or others due to mental disorder;
- q) to develop a public communication strategy, and ensure its implementation in conjunction with LASPs, to raise awareness within the wider community of adult abuse, the need to safeguard adults at risk of harm from neglect, exploitation and abuse and to highlight the contribution to safeguarding that individuals, carers, families, communities and the wider public can make;
- r) to develop and deliver an information strategy aimed at vulnerable adults, carers and families to enable them to understand safeguarding vulnerable adult processes, particularly those involved in them;
- s) to provide information and advice to practitioners, organisations, service providers and the wider public;
- t) to continually review local ways of working, identifying and promoting what works well, taking account of best practice and evidence-based knowledge gained through research and international, national and local experience to bring about service and practice improvements with regard to safeguarding vulnerable adults;
- u) to establish an internet presence to act as a repository of information relevant to the work of the NIASP, LASPs and safeguarding more generally;
- v) to provide information on a regular basis to the board/executive bodies of partner organisations and relevant government departments, particularly in relation to statutory functions; and advise on the development of information systems to facilitate data capture, management and analysis. As a minimum, information provided should cover safeguarding and protection activity, trends, support provided and outcomes for vulnerable adults involved in safeguarding processes, and how well the partnership is working so as to inform performance management, quality assessments, and policy development; and
- w) to produce an annual report to provide an update on progress against objectives set out in the Strategic Safeguarding Plan and annual Safeguarding Work Plans; to ensure that the annual report addresses, in particular, safeguarding activity, trends, outcomes for vulnerable adults

involved in safeguarding processes, and how well the partnership is working; and to ensure that reporting on safeguarding vulnerable adult activity is reflected in the annual report of each partner organisation.

### **Serious Case Reviews (SCRs)**

10. In time, NIASP will undertake SCRs, where necessary. The purpose of a SCR is:
- to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and organisations work together to safeguard vulnerable adults;
  - to review the effectiveness of procedures;
  - to inform and improve local interagency and/or inter-disciplinary practice and working together to better safeguard adults;
  - to improve practice by acting on learning and emerging best practice and making sure that the lessons learned are clearly communicated in a timely fashion, understood, and appropriate action is taken within agreed timeframes; and
  - to prepare or commission an overview report which brings together and analyses the findings of the various reports from organisations in order to make recommendations for future action.
11. Partner organisations will have their own internal or statutory review procedures to investigate serious incidents and untoward incidents. The SCR process is not intended to duplicate or replace these. There may be grounds for a SCR, a Children's Case Management Review, a Mental Health Independent Inquiry, or other formal review process. Various regulatory bodies also undertake investigations into serious incidents and Ministers can direct statutory organisations to conduct investigations or approve public inquiries. Where this is the case, a decision should be made at the outset by the decision makers involved as to whether a joint approach is required, who will lead, what needs to be addressed, who needs to be involved, who will chair and to whom the final report, joint if need be, will be made. Legal advice should be sought as necessary.
12. The circumstances which might trigger a SCR include:
- the death of a vulnerable adult (including death by suicide) and abuse or neglect is known or suspected to be a factor in the death;

- the vulnerable adult has sustained a potentially life-threatening injury through abuse, including sexual abuse, or neglect; serious or permanent impairment of health, development or well-being through abuse or neglect or serious inhuman or degrading treatment; and the case gives rise to concerns about the way in which local professionals and services work together to protect adults at risk of harm; or
  - serious abuse takes place in an institution or when multiple abusers are involved, the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time.
13. The NIASP can also consider conducting a SCR into any incident(s) or case(s) involving adults at risk of harm where it is clearly in the public interest. Terms of reference will need to be carefully constructed to explore the issues relevant to each specific case.
14. SCRs are not inquiries into how a person died or suffered injury; nor is their purpose to re-investigate, or to apportion blame. Further work will be undertaken to produce SCR Review Guidance which will cover, *inter alia*, the purpose of, and criteria which trigger, a SCR, the review process and the constitution of a SCR Panel.

### **Leadership and Accountability**

15. Each partner organisation will identify a lead at board/executive level responsible for safeguarding vulnerable adults work within the organisation; to champion the rights of vulnerable adults; and to ensure that safeguarding issues become more central to the work of the organisation. In addition, each organisation will nominate a lead manager with responsibility for safeguarding vulnerable adults to act as that organisation's representative on the NIASP and LASP, as specified. A specimen role profile for the Lead Manager Safeguarding Vulnerable Adults – NIASP & LASPs is set out in **Appendix 2**. Constructive relationships between individual workers and organisations need to be supported by senior management in each partner organisation. Each partner organisation will provide a statement setting out its role and responsibilities in relation to safeguarding vulnerable adults work, including any statutory responsibilities and services provided.
16. The NIASP and its Chair are accountable, in the first instance, to the Health and Social Care (HSC) Board. NIASP members are also, however, accountable to the organisations that they represent which, in turn, are responsible for taking any action properly falling within their respective remits. The NIASP must work to agreed written terms of reference which set out its remit, including the level of decision-making which can be agreed by partner organisations' representatives without referral back to the individual member organisation. Each partner organisation must accept that it is responsible for the contribution made by its

own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by NIASP. Each partner organisation must have a mechanism in place for considering and responding to the policy, planning and resource implications of issues brought to the attention of the organisation by its NIASP representative.

17. The HSC Board should, through the Director of Social Care and Children's Services, take lead responsibility for the establishment and effective working of the NIASP. The Director of Social Care and Children's Services, with relevant members of the NIASP, will put in place a mechanism, which ensures that ownership of safeguarding issues is promoted within all partner organisations and across all professional groups and service delivery settings in health and social care. They will also ensure that safeguarding issues of general or particular relevance to professional groups and service areas are brought to the attention of the relevant Directors in the HSC Board and the Public Health Agency (PHA) in line with the established governance arrangements within each of those bodies. In non-HSC bodies, the lead at board/executive level will ensure that safeguarding issues of a general or particular nature are dealt with in line with their organisation's established governance arrangements. All partner organisations are responsible for contributing fully and effectively to the work of the NIASP.
18. The NIASP should contribute to, and work within the framework of the planning, commissioning and performance framework established by the HSC Board in partnership with the PHA and have regard to the requirements of partner organisations. Within this framework, different organisations will also work together in different forums to plan co-ordinated action.

### **NIASP Membership**

19. The NIASP should be made up of members from the main statutory and voluntary and community organisations involved in adult safeguarding work across the region and include representation from service providers and service users. Some NIASP members may carry a dual role e.g. they may chair a LASP and represent a professional group or lead in an area of service delivery. Contributing to the work of the NIASP is an important responsibility for partner organisations.
20. Each partner organisation should ensure active participation and representation at a sufficiently senior level. Where possible, representation should be set at not less than 3rd level in the organisation, so that the NIASP can effectively influence the development of guidance, policy and practice with regard to safeguarding vulnerable adults. Where 3rd level representation is problematic, partner organisations should appoint an individual, who is sufficiently senior to represent the organisation's views and to make decisions on behalf of the



organisation. Consideration should also be given at the outset, to identifying an officer to deputise for the lead manager, should this prove necessary. A deputising officer should only be appointed on the basis of authority to represent and make decisions on behalf of the organisation. The name of the deputising officer should be communicated in writing to the chair of the NIASP. Representatives should attend regularly to ensure continuity from all partner interests. This includes membership of subcommittees or working groups.

21. Membership of NIASP will comprise a Chair and 24 members. Membership will include service users and carers or their representative groups, and be drawn from senior staff with responsibility for policy development and implementation representing:
- a) relevant professional groups from the HSC Board and PHA, including social work, primary care, medicine, nursing and allied health professionals and training managers;
  - b) Chairs of LASPs to represent the view and contribution of all its members;
  - c) the Police Service of Northern Ireland (PSNI);
  - d) the Probation Board for Northern Ireland (PBNI);
  - e) the Social Security Agency (SSA);
  - f) the Northern Ireland Housing Executive (NIHE) and providers of sheltered housing;
  - g) independent sector providers of health and social care services;
  - h) Society of Local Authority Chief Executives (Northern Ireland);
  - i) the Patient and Client Council; and
  - j) voluntary, community and private sector groups and faith communities working in the safeguarding vulnerable adults arena or relevant service provision, including advocacy, victim support, 'appropriate adult' support and services meeting the needs of specific groups experiencing neglect, exploitation or abuse. Representation from the voluntary, community and faith sectors, and service users, carers or their representative groups should also reflect the rich range of vulnerable adult interests in Northern Ireland. Where this cannot be fully accommodated on the NIASP, it should be accommodated, as far as possible, across the five LASPs.

22. The NIASP should introduce a system of decision-making by quorum. At the outset, members should agree at what number the quorum will be set and how it will be weighted to determine the validity of NIASP decision-making. The NIASP should also determine and publish nomination and selection criteria for representation by the voluntary, community, private and faith sectors who, with service users and carers or their representatives, are expected to make up one-third of the NIASP membership. It is possible that the NIASP could draw its voluntary, community and faith sector representation and representation from service users, carers or their representative groups from the suggested Adult Safeguarding Forum arrangements (see paragraphs 23 - 25). This is a matter for the NIASP. The NIASP Chair should keep membership under review and, with the agreement of other partners, revise membership as necessary to reflect the changing nature of safeguarding work.

### **THE ADULT SAFEGUARDING FORUM (ASF)**

23. Adults may be at risk for many reasons, for example, poverty, living circumstances, isolation, age, disability or deteriorating physical or mental health, alcohol or substance misuse, reduced ability to make decisions or choices, exploitation or poor family dynamics. It is essential that the voice of adults who are vulnerable, including those who have had experience of protection services, is at the centre of safeguarding and protection systems. Such systems work more effectively when they have clear ways of engaging people in local communities.
24. In recognition of the diversity of interests and the requirement to have regard to the particular needs of different groups, the NIASP, in partnership with LASPs, should consider the establishment of and provision of support to an ASF. The ASF is a mechanism by which the NIASP and LASPs facilitate much wider user participation in the work of the partnerships. Members of the ASF should be representative of the rich range of interests in Northern Ireland. As a key partner for NIASP and the LASPs, the ASF would, among other things:
- inform the development and review of strategies, policies and procedures;
  - help with the development, and promote awareness of, risk indicators;
  - help inform/equip people with information and plans to safeguard themselves;
  - help identify barriers to uptake of access to safeguarding services;
  - facilitate development of 'user-friendly' information about what to do and how to get help when needed; and

- promote access to and dialogue with local community and particular interest groups.

25. The agreed operational model should promote maximum opportunity for personal and public participation in safeguarding work at a local level, having regard to existing networks, whilst, at the same time, be able to come together on matters that are of interest across the region. The final model adopted will be a matter for the NIASP in consultation with the LASPs and should be fully operational by the end of year 2 of the establishment of the NIASP/LASPs.

### **Links with other Bodies**

26. The NIASP should also establish definitive links with:

- a) the Regulation and Quality Improvement Authority (RQIA);
- b) the Coroners Service for Northern Ireland;
- c) the Northern Ireland Court Service, including the Office of Care and Protection;
- d) relevant bodies with an enforcement and/or inspection/improvement function, e.g. the Health and Safety Executive for Northern Ireland; Criminal Justice Inspection Northern Ireland; and the Education and Training Inspectorate;
- e) the Youth Justice Agency of Northern Ireland;
- f) the Northern Ireland Fire and Rescue Service;
- g) the Northern Ireland Ambulance Service;
- h) the Northern Ireland Prison Service;
- i) child protection structures in Northern Ireland; the PPANI Strategic Management Board; the UKHTC; and the UKBA;
- j) the Co-ordinator or Senior Social Work Practitioner, Soldiers, Sailors, Airmen and Families Association (SSAFA) Forces Help;
- k) universities and colleges and other education and training providers;
- l) relevant employer and business groups;

- m) organisations representative of Section 75 groups and other communities of interest;
  - n) professional regulatory bodies, e.g. Northern Ireland Social Care Council; Nursing and Midwifery Council; General Medical Council; Health Professions Council; and Pharmaceutical Society Northern Ireland;
  - o) professional bodies and staff groups; and
  - p) other strategic partnerships, e.g. those dealing with regeneration, community safety, policing, domestic violence, drug and alcohol matters.
27. The NIASP should also make appropriate arrangements to involve other organisations and professionals in its work as necessary and the NIASP's Annual Report should provide information on their contribution to the business of the NIASP.

### **Working Groups**

28. The NIASP should consider setting up working groups to:
- a) carry out specific tasks (e.g. maintaining and updating guidance and operational procedures; developing and reviewing information sharing protocols; identifying interagency training needs and arranging appropriate training);
  - b) provide specialist advice (e.g. working with specific ethnic or cultural groups);
  - c) monitor activity and trends in adult protection work, including establishing core data sets to measure activity and outcomes; and
  - d) carry out audits and research, in conjunction with LASPs, to examine interagency safeguarding arrangements, identify good practice and highlight areas for improvement.
29. All groups working under the auspices of the NIASP should have been established by the NIASP, chaired by a NIASP member, and should work to agreed terms of reference within the framework of the Strategic Safeguarding Plan and annual Safeguarding Work Plans, and with explicit lines of communication and accountability to the NIASP. Groups may be established on a standing or time-limited basis. The continuing need for all groups should be kept under regular review by the NIASP. NIASP should, as a minimum, move quickly to establish four separate working groups to further progress work in relation to training; communication and user engagement; information management; and operational policies and procedures.

### **Chair and Secretariat**

30. It is essential that the NIASP has a Chair with established authority who has a firm grasp of safeguarding issues across the region and is of sufficient standing and expertise to command the support and respect of all member organisations. Consequently, in the first instance, the Chair of NIASP will be the Director of Social Care and Children's Services in the HSC Board or a nominated representative. Consideration should also be given to the appointment of a Vice Chair from within the membership of the NIASP to share responsibility for chairing meetings and to deputise in the chair's absence.
31. The HSC Board is responsible for providing the NIASP with a secretariat and other support services.

### **Finance and Administration**

32. NIASP expenditure, and administrative and policy support, is a matter for local agreement. As a partnership, the NIASP should be supported in its work by all its constituent members, reflecting the investment of each partner organisation in activities that are of benefit to all. This can be achieved in a variety of ways ranging from the commitment of resources to financial contributions for particular activities. The DHSSPS has provided recurrent funding for a Regional Adult Protection Officer and associated administrative provision to support the work of the NIASP and ensure the smooth running of its operation, working groups and management of its resources.
33. Each partner organisation must, however, accept that it has a responsibility to contribute to the effective working of the partnership and is responsible for the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by NIASP. Partner organisations must have a mechanism for considering and responding to the policy, planning and resource implications of issues brought to the attention of the organisation by its NIASP representative. Organisations which require resources to discharge, or change the way they discharge, their safeguarding responsibilities or to respond to any increase in safeguarding activity should bid for these in line with their usual process. Information, collected, collated and analysed by the NIASP will be of benefit in this regard.

### **NIASP Procedures**

34. The NIASP should have in place procedures covering:
  - a) reporting and responding to concerns about neglect, exploitation or abuse;

- b) determining when a case should be managed under adult protection arrangements;
- c) the management of a case from referral and through each stage of the process with associated time frames;
- d) information sharing, incorporating the principles of the Data Protection Act 1998, and which balance the requirements of confidentiality with the need to safeguard the vulnerable adult;
- e) safeguarding adults in groups known to be vulnerable and in specific circumstances;
- f) how adult protection inquiries should be conducted, including links with associated police investigations, and in particular, the circumstances in which joint enquiries are necessary and/or appropriate;
- g) the arrangements for supporting reluctant or vulnerable or intimidated witnesses, for example, the Northern Ireland Appropriate Adult Scheme which provides protections and safeguards for mentally disordered or otherwise mentally vulnerable people who are detained in police custody;
- h) the arrangements for managing complex investigations; investigations into organised abuse; and investigations involving 'out-of-area' placements;
- i) the arrangements to enable the police to make referrals to social services when adult protection concerns emerge during the course of a police investigation;
- j) the arrangements to receive referrals from the RQIA in relation to allegations of abuse in regulated establishments and agencies<sup>3</sup> and to make referrals to RQIA where a failure to comply with regulations or standards is suspected;
- k) arrangements for the investigation and management of allegations of abuse against staff members;
- l) the roles and responsibilities of particular disciplines and staff within organisations working to safeguard vulnerable adults;

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<sup>3</sup> RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003 and its supporting regulations. Services currently regulated by RQIA include residential care homes; nursing homes; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; day care settings; and boarding schools. Further information can be accessed through the RQIA website: <http://www.rqia.org.uk/home/index.cfm>

- m) a quick, effective and straightforward means of resolving professional and/or organisation differences of view in individual cases, for example, on whether an adult protection case discussion, including the form of case discussion, should be convened or about respective roles and responsibilities;
- n) participation in strategy discussions and adult protection case discussions;
- o) the involvement of carers and family members in strategy discussions and adult protection case discussions, the role of advocates as well as criteria for excluding carers/family members in exceptional circumstances;
- p) decision-making processes for monitoring vulnerable adults; and
- q) the handling of complaints from service users, families and carers about the functioning of adult protection strategy discussions and case discussions having regard to the HSC Complaints Procedure.

### **Frequency of NIASP meetings**

35. As a minimum, meeting of NIASP should occur on a quarterly basis. Regular attendance by partner members is critical for the continuity of business. In the event of an absence of any organisation for more than 2 successive meetings, the Chair will seek a fresh nomination from the organisation concerned.

### **Monitoring, Review and Audit**

36. NIASP, with LASPs, should develop and agree a 3-5 year audit/review plan with performance indicators against which audits/reviews will be conducted. In conjunction with LASPs, the NIASP should conduct audits/reviews against the plan to, *inter alia*, monitor and evaluate the way in which their policies, procedures and practices for the protection of vulnerable adults are working; how well organisations respond individually and collectively to allegations of abuse; and how well the partnerships are working. For this purpose, organisations should work together. Feedback on performance to all organisations should be a key feature of the audit/review process.
37. In determining the content of the audit/review plan, NIASP, with LASPs, should consider the following elements:
- an evaluation of community and public understanding – the extent to which there is an awareness of indicators of possible abuse; the policy and procedures and services for safeguarding vulnerable adults; and how to access them;

- links with other systems for protecting those at risk – for example, child protection, public protection, domestic violence, victim support and community safety;
  - an evaluation of how staff and organisations are working together (e.g. timely and appropriate information sharing; sharing of skills, knowledge and expertise; the fostering of shared decision-making, shared ownership and shared responsibility; and effective co-ordination of responses and incorporation of different professional/organisation perspectives) and how far policies and procedures continue to be appropriate;
  - the extent to which operational guidance continues to be appropriate in general and, in the light of reported cases of abuse, in particular;
  - increase in staff awareness of abuse and safeguarding processes across all organisations and service settings – the extent to which there is an awareness of indicators of possible abuse; the policy and procedures and services for safeguarding vulnerable adults; and how to access them;
  - the range, uptake and quality of training available to staff in all organisations relevant to their roles and responsibilities;
  - the performance and quality of services for the protection of vulnerable adults;
  - the conduct of investigations in individual cases;
  - identification of barriers to the uptake of safeguarding services; and
  - the development of services and models of practice to respond to the needs of adults who have been abused.
38. The above elements, proportionate to the role of partner organisations, should form the basis for informing outcome measures which can be used by partner organisations, and commissioners and providers of services to monitor and evaluate effectiveness of service provision. It should also inform the planning and reporting processes and, for partner organisations, identify the need, if any, for resources to deliver service or practice change or development. It will also help identify any matters that require clarification of, or further development in, government policy with regard to safeguarding. Bids for resources should be progressed in line with each partner organisation's usual process.



## **Strategic Safeguarding Plan and Annual Safeguarding Work Plans**

39. The NIASP will, in conjunction with LASPs set out its strategy for safeguarding vulnerable adults with agreed objectives and priorities for its work in a rolling 3-5 year Strategic Safeguarding Plan for Northern Ireland. The Strategic Safeguarding Plan will be supported by annual Safeguarding Work Plans. The annual Safeguarding Work Plan should set out a work programme for the forthcoming year and include measurable objectives. The NIASP's plan should both contribute to, and derive from the framework for planning and commissioning health and social care services and their performance management. It should reflect the objectives of partner organisations and be endorsed by senior managers in each of the organisations.
40. The NIASP may wish to make the Strategic Safeguarding Plan and Safeguarding Work Plans, or an edited version of them, available to a wider audience, for example, to explain to the wider community the work of local organisations in helping to safeguard vulnerable adults.
41. Production of comprehensive communication and information strategies and associated action plans, in partnership with LASPs will be a priority in Year 1 of the NIASP's work.

## **Annual Report – NIASP and LASP**

42. The annual report presents an opportunity for the NIASP and LASPs to reflect on their roles, responsibilities and functioning. The reports also provide an opportunity to promote dialogue within and between organisations and to communicate with the wider public.
43. The reports should contain analysis, review and comment on NIASP and LASP processes and functioning, and on how well they are discharging their responsibilities. The reports should also include statements of progress against objectives for the previous year; indicate how well services work individually and collectively to safeguard vulnerable adults and how well the partnerships are working; set out developments in service and practice; actions for improvement still required and timeframe for delivery. Management information on adult protection activity and outcomes in the course of the previous year and objectives for the coming year should also be included.
44. As a minimum NIASP's Annual Report should contain sections on:
  - a) membership, vision, roles and responsibilities and the principles underpinning safeguarding work with vulnerable adults;
  - b) the work of the NIASP in-year, including information about activity undertaken by sub-groups and partner organisations;

- c) information on activity, trends, support provided and outcomes in relation to safeguarding and the protection of adults at risk; and audits undertaken (**Appendix 3** provides an outline of matters for consideration);
  - d) information on training provided and community and public awareness work undertaken;
  - e) reports from the LASPs;
  - f) feedback on service user, family and carer experience of safeguarding activity;
  - g) audit, review and research activity undertaken;
  - h) its conclusions about the effectiveness of safeguarding arrangements, how well organisations have worked together and the effectiveness of partnership arrangements and what, if anything needs to be addressed, by whom and by when; and
  - i) its objectives for the coming year.
45. Constituent organisations should, commensurate with their role in safeguarding, provide the NIASP with management information on safeguarding work in general and, in particular, on the level of activity, trends, support provided and outcomes in adult protection work within their organisation on an annual basis. The information provided should not include identifying details of individuals. Each organisation should submit annual progress reports to its board/executive body to ensure that adult safeguarding and protection requirements are part of the organisation's overall approach to service provision and service development. Reports to each board/executive body should be commensurate with the organisation's safeguarding role and be sufficient for it to be assured that it is discharging its responsibilities and partnership commitments appropriately and effectively. NIASP may need to provide further guidance on reporting requirements as they apply to all partner organisations. NIASP should keep reporting requirements under review. The structure of the LASPs' Annual Reports should reflect that of the NIASP as set out above. An item about work undertaken in relation to safeguarding vulnerable adults should be included in each organisation's annual report.
46. The NIASP and LASPs will also want to consider how to make the findings set out in their reports more widely available:
- within member organisations;
  - to other organisations with a role in, and responsibilities for, safeguarding and the support and protection of vulnerable adults;

- to service users and carers; and
- to the general public.

The NIASP and LASPs will therefore want to consider the issue of publication and the formats in which the reports' findings are made available; the NIASP web site will be an important mechanism for dissemination of Annual Reports and information relevant to safeguarding vulnerable adults more generally.

## **THE LOCAL ADULT SAFEGUARDING PARTNERSHIP (LASP)**

### **Role and Responsibilities**

47. The role of the LASP located within each of the HSC Trust areas is to implement locally the NIASP's guidance and operational policy and procedures ensuring a high standard of professional practice. Its main tasks are:
- a) to work within, and contribute to the NIASP Strategic Safeguarding Plan, and ultimately the framework for planning, commissioning and performance management of health and social care services having due regard to the objectives of partner organisations;
  - b) to contribute to delivery of the annual Safeguarding Work Plan;
  - c) to implement the NIASP's guidance and operational policies and procedures;
  - d) in partnership with the NIASP to measure how and to what degree the objectives, performance indicators and outcome measures set by the NIASP have improved outcomes for vulnerable adults in the locality;
  - e) to monitor and evaluate how well local services work together to safeguard vulnerable adults. This should be done in partnership with the NIASP and form part of the NIASP annual Safeguarding Work Plan;
  - f) to encourage and develop good working relationships between different services, professionals, and community, voluntary and private sector groups with the aim of developing trust and mutual understanding;
  - g) to ensure that each partner organisation has a clear, well-publicised policy of "Zero-Tolerance" of neglect, exploitation or abuse wherever they occur;
  - h) to ensure that there are strong and effective links between the LASP and MARAC, PPANI and SSAFA Forces Help (where there is a large service base in the area) at local level;

- i) to develop and maintain strong links with local child protection structures;
- j) to properly integrate adult safeguarding strategies with other relevant strategies and procedures, e.g. child protection; domestic violence; sexual violence and abuse; human trafficking; and the assessment and management of individuals who may be a risk to themselves or others due to mental disorder;
- k) to advise the NIASP and LASP's constituent organisations on resource needs;
- l) to develop an outline training plan, contribute to the NIASP training and development strategy and to the delivery of training and development programmes on a multi-agency/disciplinary basis and, in partnership with NIASP, to assess how identified training/development needs are being met;
- m) to promote public awareness about adult safeguarding and protection services in keeping with the NIASP public communication and information strategies; and
- n) to provide an annual report to the NIASP.

### **Accountability**

- 48. The LASP as a body is accountable to the HSC Trust in which it is located, although its members are accountable to the organisations they represent. The LASP should work within the agreed NIASP Strategic Safeguarding Plan and associated Safeguarding Work Plans, guidance and adult protection operational policies and procedures, which they do not have the discretion to amend. Each partner organisation should accept that it is responsible for monitoring the performance of its own representative.
- 49. Each partner organisation must accept that it has a responsibility to contribute to the effective working of the partnership and is responsible for the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by the LASP. Each partner organisation must have procedures in place for considering reports from its LASP representative and for responding to the policy, planning and resource implications of issues brought to its attention by its LASP representative.

### **Terms of Reference**

- 50. The LASP should work within agreed terms of reference that set out its remit. The terms of reference should be agreed with members of the LASP, endorsed by the NIASP, and include the level of decision-making that may be agreed by

partner organisation representatives, without referral back to individual member organisations.

### **LASP Membership**

51. The LASP should be made up of members from the main statutory and voluntary and community organisations involved in adult safeguarding work and service providers in the HSC Trust's area, and include representation from service users. Each partner organisation should ensure active participation and representation at a sufficiently senior level so that the LASP is effective in the implementation of guidance, policy and procedures at a local level, including engagement with service users, families, carers and the wider public. Membership will comprise a Chair and 24 members which should include service users and carers or their representative groups and practitioners and managers from a range of disciplines and organisations **in the HSC Trust area**, including:
- a) relevant professional groups from the HSC Trust, including social work, medicine, nursing, allied health professionals and training managers;
  - b) the PSNI;
  - c) general practitioners;
  - d) the relevant Local Commissioning Group;
  - e) the PBNI;
  - f) the SSA;
  - g) the NIHE and providers of sheltered housing;
  - h) independent sector providers of health and social care services;
  - i) relevant District Council(s);
  - j) the Patient and Client Council; and
  - k) voluntary, community and private sector groups and faith communities working in the safeguarding vulnerable adults arena or relevant service provision, including advocacy, victim support, 'appropriate adult' support and services meeting the needs of specific groups experiencing neglect, exploitation or abuse. Representation from the voluntary, community and faith sectors, and service users, carers or their representative groups should also reflect the rich range of vulnerable adult interests in Northern Ireland.

52. Consideration should also be given, at the outset, to identifying an officer to deputise for the lead manager, should this prove necessary. A deputising officer should only be appointed on the basis of authority to represent and make decisions on behalf of the organisation. The name of the deputising officer should be communicated in writing to the chair of the LASP. Representatives should attend regularly to ensure continuity from all partner interests. This includes membership of subcommittees or working groups.
53. The LASP, in consultation with NIASP, should introduce a system of decision-making by quorum. At the outset, members should agree at what number the quorum will be set and how it will be weighted to determine the validity of LASP decision-making. The LASP, in consultation with NIASP, should also determine and publish nomination and selection criteria for representation by the voluntary, community, private and faith sectors who with service users and carers or their representative groups are expected to make up one-third of the LASP membership. It is possible that the LASP could draw its voluntary, community and faith sector representation and representation from service users, carers or their representative groups from the suggested Adult Safeguarding Forum arrangements (see paragraphs 23 - 25). This is a matter for the LASPs. The LASP Chair should keep membership under review and, with the agreement of other partners, revise membership as necessary to reflect the changing nature of safeguarding work.

### **Links with other Bodies**

54. The LASP should seek to establish links locally with RQIA and with other relevant local professionals, bodies, organisations and groups which have a contribution to make with regard to safeguarding vulnerable adults, for example, relevant employer and business groups; organisations representative of Section 75 groups; and other communities of interest. Examples of local partnership arrangements with which links should also be forged include: Domestic Violence Partnerships, Child Protection Panels, Local Area Public Protection Panels and Community Safety Partnerships. Where such links are established, the LASP's Annual Report should provide information on their contribution to the work of the LASP.

### **Working Groups**

55. The LASP will also have the capacity to utilise sub-groups to reflect 'special interest' and service user needs and to draw on the expertise of groups and practitioners, for example, with regard to accident & emergency departments, mental health, learning disability, physical disability and sensory impairment, dementia and geriatrics. Groups may be established on a standing or time-limited basis. The continuing need for all groups should be kept under regular review by the LASP. As a minimum, LASPs will need to move quickly to establish groups in relation to training; communication and user engagement;

information management; and operational policies and procedures to mirror arrangements within the NIASP.

## Chairing

56. At the outset, the LASP should be chaired by the Trust's Executive Director of Social Work or a senior designated nominee, on the grounds that existing partnership arrangements are led by senior social care staff. Over time, it may be possible to rotate chairing arrangements among partnership members. However, it is essential that the Chair has a firm grasp of local safeguarding issues and is of sufficient standing and expertise to command the support and respect of all member organisations. Consideration should also be given to the appointment of a Vice Chair from within the membership of the LASP to share responsibility for chairing meetings and to deputise in the chair's absence. The Trust's Executive Director of Social Work or nominee, with relevant members of the LASP, will put in place a mechanism, which ensures that ownership of safeguarding issues is promoted across all professional groups and service delivery settings in health and social care. They will also ensure that safeguarding issues of general or particular relevance to professional groups and service areas within the HSC Trust are brought to the attention of the relevant Trust Director, in line with established governance arrangements within the Trust. In non-HSC bodies, the lead at board/executive level will ensure that safeguarding issues of a general or particular nature are dealt with in line with their organisation's established governance arrangements.

## Finance and Administration

57. The HSC Trust is responsible for core funding the LASP and providing it with a secretariat and other support services. As a partnership, the LASP should be supported in its work by all its constituent organisations, reflecting the investment of each partner organisation in activities that are of benefit to all. This can be achieved in a variety of ways ranging from the commitment of resources to financial contributions for particular activities. The DHSSPS has provided recurrent funding for a Specialist Adult Protection Manager and associated administrative provision to support the work of each LASP to ensure the smooth running of its operation and management of its resources.
58. Each partner organisation must, however, accept that it has a responsibility to contribute to the effective working of the partnership and is responsible for the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by LASP. Partner organisations must have a mechanism for considering and responding to the policy, planning and resource implications of issues brought to the attention of the organisation by its LASP representative. Organisations which require resources to discharge, or change the way they discharge, their safeguarding

responsibilities or to respond to any increase in safeguarding activity should bid for these in line with their usual process. Information, collected, collated and analysed by the LASP will be of benefit in this regard.

### **Frequency of LASP meetings**

59. At a minimum, meeting of LASPs should occur on a quarterly basis, synchronised with the quarterly meeting of the NIASP. Regular attendance by partner members is critical for the continuity of business. In the event of an absence of an organisation for more than 2 successive meetings, the Chair will seek a fresh nomination from the organisation concerned.

### **Monitoring, Review and Audit**

60. In accordance with the agreed 3-5 year audit/review plan and in conjunction with the NIASP, LASPs, should audit, monitor and review the way in which their policies, procedures and practices for the protection of vulnerable adults are working; how well organisations respond individually and collectively to allegations of abuse; and how well the partnership is working. Further guidance in determining the content of the audit/review process is set out in paragraph 37.

### **Information for the LASP**

61. Constituent organisations should, commensurate with their role in safeguarding, provide the LASP with management information on safeguarding work in general and, in particular, on the level of activity, trends, support provided and outcomes in adult protection work within their organisation on an annual basis. The information provided should not include information capable of identifying any individual (see also paragraphs 42 - 46).

### **Information from the LASP**

62. The LASP should review annually the adult safeguarding work in its area and plan for the year ahead. This information should be submitted to the HSC Trust board, copied to the NIASP and circulated to all constituent organisations as soon as possible after the end of the financial year. As safeguarding work evolves, there should be a periodic review by NIASP, in conjunction with LASPs, of the information collected to make sure of its continued relevance and to identify and address any information gaps (see also paragraphs 42 - 46).



**ADULT SAFEGUARDING IN NORTHERN IRELAND: OBJECTIVES TO OUTCOMES – AN ILLUSTRATION**

Objectives...	...pursued through functions...	... help produce outputs...	...that contribute to overall outcomes...
<p>1. To secure effective co-ordination of what is done by each person and partner organisation on the NIASP for the purpose of safeguarding and promoting the welfare of vulnerable adults in Northern Ireland</p>	<p>Overseeing the development of person-centred, rights-based policies and procedures for safeguarding and promoting the welfare of vulnerable adults, including:</p> <ul style="list-style-type: none"> <li>- action where there are concerns, including thresholds;</li> <li>- training of persons who work with vulnerable adults;</li> <li>- co-operation with relevant authorities in other parts of the United Kingdom and in the Republic of Ireland; and</li> <li>- participating in the planning of services for vulnerable adults in Northern Ireland.</li> </ul>	<p>Effective local work to safeguard and promote the welfare of vulnerable adults</p>	<p>The general well-being of vulnerable adults is promoted and, in particular, they are kept safe.</p>
<p>2. To ensure the effectiveness of what is done by each person or partner organisation for that purpose.</p>	<p>Monitoring effectiveness of what is done to safeguard and promote the welfare of vulnerable adults.</p> <p>Procedures to ensure a co-ordinated response to suspected or allegations of abuse.</p> <p>Collecting, collating and analysing information abuse and operation of safeguarding procedures.</p> <p>In time, ensuring that Serious Case Reviews are undertaken.</p>	<p>Evaluating effectiveness and advising on way to improve.</p>	
<p>3. To raise awareness of adult abuse and communicate the need to safeguard and promote the welfare of vulnerable adults to the wider community.</p>	<p>Raise awareness of:</p> <ul style="list-style-type: none"> <li>- adult abuse and risk to vulnerable adults and the danger signs in relation to neglect, exploitation and abuse; and</li> <li>- sources of help and how to access them for vulnerable adults, carers, families and the wider community.</li> </ul>	<p>All citizens accept mutual responsibility to safeguard the vulnerable, to be aware of the danger signs and to act on concerns.</p>	

**APPENDIX 2****ROLE PROFILE FOR LEAD MANAGER SAFEGUARDING VULNERABLE ADULTS – NIASP & LASPS**

1. To represent their organisation at the NIASP or LASP, as appropriate.
2. To promote the role of their organisation within safeguarding adults work. To provide a summary of that role to the LASP and NIASP, as appropriate.
3. To promote effective multi-professional, inter-disciplinary, interagency working on safeguarding adult issues and in particular in relation to adult protection procedures. To negotiate changes to internal and interagency processes to facilitate this.
4. To lead the implementation of safeguarding adults work within their organisation in line with current good practice, including:
  - the safeguarding of people using the organisation’s services;
  - the appropriate use of the regional adult protection procedures; and
  - ensuring staff, volunteers and service users and carers are informed about safeguarding adults work and have appropriate skills relevant to their role.
5. To give regular reports to the LASP and NIASP, as appropriate, of progress on implementation of safeguarding adults work within their organisation including:
  - numbers and roles of staff trained, including range, uptake and quality of training;
  - monitoring and quality assurance data in relation to adult protection referrals;
  - services delivered to victims or perpetrators of adult abuse; and
  - any issues arising in relation to the implementation of safeguarding adults work.
6. To ensure that the organisation is appropriately and consistently represented on NIASP, LASP or any sub-groups, work groups or task groups.
7. To report to the organisation’s board/executive body member with responsibility for Safeguarding Adults and make regular reports to that board/executive body and, in particular, to identify any resources required to discharge, or change the way safeguarding responsibilities are discharged or as a consequence of any increase in safeguarding to ensure that bids for resources are progressed in line with the organisation’s usual process.
8. To promote the work of the LASP and NIASP, as appropriate and represent the NIASP or LASP in other multi-organisation forums as agreed.

**APPENDIX 3****MANAGEMENT INFORMATION – A SUGGESTED OUTLINE**

Information should be routinely gathered in two categories, namely:

1. Activity and trends; and
2. Outcomes and performance indicators.

**1. INFORMATION ON ACTIVITY AND TRENDS****a) Safeguarding activity to include, for example, evidence of:**

- awareness campaigns, e.g. about abuse and how to prevent it; support services and how to access them; promotion of health and well-being and social inclusion;
- stay safe, keep safe and dignity in care initiatives;
- Safeguarding Adults Conferences which incorporate the range of safeguarding networks;
- publicity materials available in formats and languages required;
- participation by partnerships/member organisations in events to mark international awareness days, e.g. World Elder Abuse Day which happens each year on 15 June;
- information and awareness raising events held in and by partner organisations;
- systems in place for the management of malpractice and to ensure, as far as possible, that service users are safeguarded against potential risks from employees;
- embedding of safeguarding and protection policies in service agreements/contracts with providers of services to adults who are vulnerable;
- proactivity in early intervention and promotion of a culture of service users' rights to high standards of care, treatment and service;
- availability of advocacy services which reflect the needs of the population served; and/or
- dissemination of learning by staff/organisations from safeguarding/protection work.

**b) Protection work to include:**

- number and source of referrals, e.g. self-referral, carer/family member, friend, member of public, care worker, service provider, police, acute hospital, incl. A&E, RQIA, GP, anonymous, other;
- information about the abused person, such as age, marital and dependent status, gender, ethnicity and primary service user group, e.g. physical disability, sensory impairment, learning disability, older person, dementia, mental health, acquired brain injury, alcohol/substance misuse, other, e.g. data collection should be sensitive to abuse perpetrated because of an individual's religion, political opinion or sexual orientation;
- information about the alleged abuser, e.g. institutional setting, partner, main family carer, other relationship paid carer, friend, service user, professional, other family member, stranger;
- type(s) of abuse referred using commonly agreed categories as suggested in *Safeguarding Vulnerable Adults* (September 2006), Paragraph 3.3, i.e. physical abuse (including inappropriate restraint or use of medication); sexual abuse; psychological abuse; financial or material abuse; neglect and acts of omission; institutional abuse; and discriminatory abuse;
- location in which abuse took place, e.g. own home, alleged abuser's home, other person's home, residential care home (statutory, voluntary or private), nursing home, day care setting; adult placement setting, hospital, public place;
- outcomes of investigation, e.g. abuse discontinued, allegation unsubstantiated, current/open case, changes in care arrangements, increased monitoring of situation, family/carer support, use of protective legislation (specify), admission to residential care/hospital, specialist external service, vulnerable adult reluctant to continue, allegation withdrawn, lack of evidence, awaiting outcome of police investigation, case proven, prosecution brought, not adult protection;
- whether the person is already known to any organisation or whether it is a new referral;
- how the profile of activity has changed from previous year; and
- service user/carer views on how policy has worked for them.

**c) Processes, by Programme of Care, to include:**

- number of current cases;
- number of cases closed;
- number of new referrals, identifying whether received in or out of hours;

- number of consultations with designated officers
- number of initial assessments/screenings;
- number of strategy discussions;
- number of case discussions, identifying participation by service user, family and carer;
- number of single agency investigations;
- number of joint protocol investigations;
- number of 'complex' investigations, including profile of activity undertaken, e.g. interviews of service users, staff, etc;
- number of investigations involving regulated establishments and agencies, by type, e.g. residential care homes, nursing homes, day care settings, domiciliary agencies, etc;
- number of care and protection plans;
- number of review meetings;
- number of other related professional meetings;
- number of repeat victims of abuse;
- proactive use of available legislative provision to safeguard, e.g. guardianship, powers of attorney, non-molestation orders, etc;
- percentage of successful prosecutions; and
- number and nature of interventions that prevented further abuse.

**d) The partnership, to include:**

- representation of member organisations and level of representation;
- attendances at meetings;
- representing organisation needs to LASP/NIASP;
- representing LASP/NIASP to organisation;
- contributing to annual report;
- single agency and interagency training activity; and

- initiatives to engage with service users, family, carers and wider public.

To minimise the reporting burden, NIASP and LASPs should have regard to other reporting arrangements within the organisation, for example in HSC Trusts, reports provided:

- in compliance with Circular: CC3/02 - Role and Responsibilities of Directors for the Care and Protection of Children;
- in relation to serious adverse incident reporting;
- in relation to the discharge of delegated statutory functions; and
- in relation to the monitoring of complaints and their resolution.

## 2. OUTCOMES AND PERFORMANCE INDICATORS

Outcomes are important not only in terms of the experience of the vulnerable adult but also in focusing organisations on their objectives and giving greater priority to safeguarding as core area of work for partner organisations and others. Outcomes and performance indicators may include:

- A demonstrated improvement in the quality of life for a person who had been 'safeguarded'.
- A reduction in incidents of abuse reported.
- Increased numbers of care and protection plans created and closed.
- Identification of under-reporting by programmes of care, teams and/or sectors and management/organisational action to address this.
- Support for "whistleblowers".
- Timeliness of organisation responses.
- A quantifiably better understanding of abuse issues in local communities.
- A quantifiably better understanding of abuse issues in constituent parts of partner organisations.
- People empowered and better able to protect themselves.
- People able to raise alerts and better awareness of safeguarding.
- More referrals, on the basis of robust and thorough investigative and decision-making processes, to the Independent Safeguarding Authority (ISA) in accordance with Safeguarding Vulnerable Groups requirements.

- Progress with regard to ISA-registration in accordance with the phasing rules determined by AccessNI.
- More referrals, on the basis of robust and thorough investigative and decision-making processes, to professional regulatory bodies.
- Improved service planning.
- Better partnership arrangements.
- Effective working with other strategic partnerships.
- More and better training.
- Continuous improvement in the quality of record keeping, personalisation of care and protection plans, communication of information and management of records.
- Initiatives which demonstrate a move from a reactive to a proactive safeguarding system.

Info Reg # 1

1-1 19.001

## TYPE OF DOCUMENT

Trust Policy & Procedure for approval by Trust Policy Committee

<b>REFERENCE NUMBER</b>	TP044/10
<b>TITLE</b>	Belfast Health & Social Care Trust Adult Protection Policy & Procedures <span style="float: right;">✖</span>
<b>Summary</b>	The Belfast Health & Social Care Trust recognises its duty to respond to the needs of vulnerable adults who are subject to alleged, suspected or confirmed abuse. This policy aims to ensure that all Trust staff and all services commissioned by the Trust have a clear understanding of their obligation to support and protect vulnerable adults. The policy provides a framework within which all those involved in adult protection work should operate.
<b>Purpose</b>	This policy is designed to provide a clear statement of the Belfast Trust's commitment to respond in a comprehensive and co-ordinated way in relation to adult protection work. The policy outlines the Trust's awareness of and commitment to delivering on regionally agreed policies, procedures and protocols. The policy also sets the context within which the Trust will deliver Adult Protection Procedures (see Trust's Adult Protection Procedures).
<b>Supersedes</b>	Legacy Trust procedures
<b>Operational date</b>	1 June 2010
<b>Review date</b>	1 June 2012
<b>Version Number</b>	V1
<b>Director Responsible</b>	Bernie McNally
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Adult Protection Policy &amp; Procedures – June 2010



<b>Additional Author(s)</b>	Yvonne McKnight - 90565707
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**Version Record  
Policy Record**

Date	Version	Author	Comments
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21/12/09 30/02/10	V0.2	Una Macauley / Yvonne McKnight	Consultation with Acute Hospital Sector, Learning Disability Service, Mental Health Service, Physical Disability Service, Older People Services.
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Chief Executive	Sign Off	19.05.10	V1

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval		
Policy Committee	Ratify		
Executive Team	Authorise		
Appropriate Director	Sign Off		

Local Approval Process

	Approval		
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Dissemination

Areas :	




**For Director of Social and Primary Care**  
19 May 2010

**Chief Executive**  
19 May 2010

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**Full Description**

**1. Title: Adult Protection Policy & Procedure**

**2. Introduction**

The Belfast Health & Social Care Trust recognises that abuse is a violation of an individual's human and civil rights. The Trust has a zero tolerance in relation to all forms of abuse and exploitation. The Trust is fully committed to ensuring that vulnerable adults who are subject to alleged, suspected or confirmed abuse are supported and protected from harm.

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This Policy aims to ensure that all Trust staff and services commissioned by the Trust who are involved in the care of Vulnerable Adults who are subject to alleged, suspected or confirmed abuse, respond in a co-ordinated and consistent way to support and protect the Vulnerable Adult.

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This Policy replaces Legacy Trust Policies & Procedures. The Belfast Health & Social Care Trust are fully committed to delivering on Safeguarding Vulnerable Adults, the Regional Adult Protection Policy and Procedural Guidance (September 2006).

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This Trust Operational Policy endorses legislative and regional requirements in relation to adult protection work.

It is recommended that staff working in the field of adult protection read this document in conjunction with:

- Safeguarding Vulnerable Adults, Regional Adult Protection Policy & Procedural Guidance (Sept 2006)
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults. (Jul 2009)
- Achieving Best Evidence In Criminal Proceedings (NI) guidance for Vulnerable or Intimidated witnesses, including children. (2003)
- Regulation Quality Improvement Authority's Procedures for Responding to Allegations, Suspicions or Incidents of Abuse of Vulnerable Adults in Regulated Service (Nov 2007)
- The Safeguarding Vulnerable Groups Order (N.I) 2007
- Guidance on Consent & Capacity DHSPS

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The Trust is committed to ensuring policies and procedures are reviewed and updated regularly. It is recognised that the DHSSPS are currently working on a new Government policy and this policy and procedure will be reviewed as soon as the new Government Policy is issued. It is therefore anticipated that the first review will be in 12/18 months time and thereafter reviewed every 2 years.

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**3. Purpose**

This policy is designed to provide a clear, comprehensive and consistent approach to the management of alleged, suspected or confirmed abuse of vulnerable adults within the Belfast Health & Social Care Trust. The Belfast Health & Social Care Trust are fully committed to delivering on Safeguarding Vulnerable Adults, the Regional Adult Protection Policy and Procedural Guidance (September 2006). The attached Adult Protection Procedures set out Trust expectations regarding reporting requirements and responsibilities in terms of investigation and protection of the vulnerable adult.

**4. The Scope:**

This Policy is relevant to all staff working within the Trust who, either directly or indirectly come into contact with Vulnerable Adults who are subject to alleged, suspected or confirmed abuse. This Policy is of particular relevance to staff working within Older People Service, Learning Disability Services, Mental Health Services and Physical Health & Disability Services including Sensory Impaired. The Policy recognises that abuse of Vulnerable Adults can happen anywhere including Community, Hospital, Care Facilities and Day Care and the policy is therefore applicable in all settings. It covers all types of abuse including neglect and recognises that vulnerable people cannot always protect themselves.

This Policy does not operate independently of other Belfast Trust Policies & Procedures. Policies and Procedures such as Complaints, Whistle Blowing and Disciplinary Procedures should be implemented concurrently in order to ensure the protection of the Vulnerable Adults.

**5. Objectives:**

- 5.1 The overall aim of the Policy is to prevent abuse by providing a framework within which all Trust staff should operate to protect vulnerable adults.
- 5.2 To comply with Regional requirements as outlined / defined in 'Safeguarding Vulnerable Adult Protection Policy & Procedural Guidance (2006)'
- 5.3 To set out clearly the Trust's expectations in relation to identification and management of cases of suspected, alleged or confirmed abuse of a vulnerable adult.
- 5.4 To clarify the roles and responsibilities of those involved in adult protection work.
- 5.5 To ensure a comprehensive and consistent approach is taken in relation to adult protection work across the Trust
- 5.6 To promote effective multi-disciplinary and multi-agency working in relation to abuse investigations and protection planning.
- 5.7 To highlight and reaffirm the Trust's commitment to Regional Protocols, in particular the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009) and meet requirements under Achieving Best Evidence in Criminal Proceedings (NI) Guidance for Vulnerable and Intimidated Witnesses including Children (2003)
- 5.8 To ensure early detection of abuse of vulnerable adults and prompt intervention to offer protection.
- 5.9 To comply with legislative requirements as defined
- 5.10 To provide a clear policy & procedures for managers and staff.

**6. Roles and Responsibilities:**

To achieve these objectives, clarity regarding roles and responsibilities is required.

**Trust Board**

1. To ensure that relevant Policies and Procedures are in place in relation to Adult Protection work.
2. To commit appropriate resources to ensure that staff working in the field of Adult Protection are adequately trained.

**Service Group: Directors / Co-Directors / Service Managers**

To ensure that all staff within their areas of responsibility are familiar with the Trust's Adult Protection Policy and have a clear understanding of their role and responsibility.

To provide relevant training and support to staff to ensure they are adequately equipped to deliver in terms of their responsibilities in relation to Adult Protection work.

To ensure that the complement of staff trained as Designated Officers, Investigating Officers and Specialist Interviewers (ABE) is sufficient to meet the needs of the service.

**Employees**

To adhere to Adult Protection Policy & Procedure.

To attend relevant training.

To raise issues of concern promptly with line manager.

To follow reporting procedures and protocols, with particular reference to Regional Reporting arrangements.

To adhere to Protocol for Joint Investigation of Alleged and Suspected Abuse of Vulnerable Adults (2009).

Regulated Services must adhere to Regulation Quality & Improvement Authority reporting procedures.

**7. The definition and background of the Policy**

The 'No Secrets: Guidance on Developing & Implementing Multi-agency Policies and Procedures to Protection Vulnerable Adults from Abuse' was issued by the Department of Health (2000) and required Trusts to work jointly with other relevant Agencies to protect vulnerable adults from abuse.

- Achieving Best Evidence in Criminal Proceedings (NI) Home Office 2002
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2003)

Safeguarding Vulnerable Adults Regional Policy and Procedural Guidance was issued by the Regional Adult Protection Forum and endorsed by the DHPSS and is recognised by the Belfast Trust as the framework within which all work in relation to Adult Protection should take place. The Belfast Trust Adult Protection Operational Policy both endorses and complements the Regional Policy. It reaffirms the Trust's commitment to delivering on Regional Requirements and builds on this by setting out Trust requirements in relation to Governance arrangements.

## 8. Policy / Guidelines description:

### 8.1 Vulnerable Adult

The Trust has adopted Safeguarding Vulnerable Adults definition of a Vulnerable Adult as:

'a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation'(1). Therefore adults assessed by the Trust as eligible for a service from one of the service groups are defined as vulnerable adults.

This includes adults with physical, sensory and mental impairments and learning disabilities, howsoever those impairments have arisen; e.g. whether present from birth or due to advancing age, chronic illness or injury.

### 8.2 Abuse

The definition of abuse adopted by the Belfast Trust is derived from Regional Guidance issued by the Management Executive, Department of Health and Social Services, in 1996, which states that abuse is:

'The physical, psychological, emotional, financial or sexual maltreatment or neglect of a Vulnerable Adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship'(2)

'Forms of abuse can be categorised as follows:

- physical abuse (including inappropriate restraint or use of medication)
- sexual abuse
- psychological abuse
- financial or material abuse
- neglect and acts of omission
- institutional abuse and
- discriminatory abuse

Incidents of abuse may be multiple, either to one person in a continuing relationship or service context, or to more than one person at a time.

Any or all types of abuse may be perpetrated as the result of deliberate intent and targeting of vulnerable people, negligence or ignorance.

The Law Commission in its 1995 report makes use of the concept of significant harm as an important threshold when considering the nature of intervention and defines this as including not only ill-treatment (including sexual abuse and forms of ill-treatment which are not physical) but also the impairment of physical, intellectual, emotional, social or behavioural development. Significant harm may include the degree, extent, duration and frequency of harm'.(3)

**8.3 Designated Officer**

Is a professional member of Trust staff with management experience who has received additional specialist training in relation to adult protection work. The Designated Officer has a number of key functions under the Adult Protection Policy, these include; deciding whether an investigation under Adult Protection Policy & Procedures is appropriate; nominating an Investigating Officer; providing line management support to the Investigating Officer; and overall responsibility for the co-ordination of the investigation. The Designated Officer's role involves directing of the investigation and he/she is responsible for the decision making. Only staff trained and appointed as Designated Officers should fulfil this role.

**8.4 Investigating Officer**

Is a professional member of Trust staff who has had additional specialist training in relation to adult protection work. The Investigating Officer is responsible for conducting an adult protection investigation and for ensuring that an effective protection plan is in place. Only staff trained and appointed as Investigating Officer by their Service Group can fulfil this role.

**8.5 Specialist Interviewer**

Is a professional member of Trust staff who has successfully completed the eight day Achieving Best Evidence course. The role involves joint working with PSNI in terms of interviewing vulnerable or intimidated witnesses.

**8.6 Staff trained in the Protocol for Joint Investigation**

Most Adult Protection investigations involve a Designated Officer and an Investigating Officer. In cases where crime is suspected, a Joint Agency Consultation with PSNI should take place. If a Joint Investigation is initiated, staff trained in the Protocol for Joint Investigation can be nominated by the Designated Officer to gather preliminary information to help inform the strategy planning meeting. Staff trained in Joint Protocol can also, in conjunction with PSNI, conduct a clarification discussion with a vulnerable adult. However it must be stressed that only staff trained as Specialist Interviewers under Achieving Best Evidence can conduct investigative interviews.

**9. Policy Statement:**

- 9.1 The Belfast Trust recognises that abuse of vulnerable adults is everyone's business and therefore requires all Trust staff and services commissioned by the Trust (private, voluntary, independent sector) to be alert to the possibility of abuse.
- 9.2 Trust staff who have concerns regarding alleged, suspected or confirmed abuse of a vulnerable adult, have an obligation to report their concerns immediately.
- 9.3 All allegations of abuse of a vulnerable adult will be fully investigated and a protection plan put in place where appropriate.
- 9.4 The Belfast Trust is fully committed to ensure that staff working with vulnerable adults are properly vetted in keeping with Safeguarding Vulnerable Groups Order (N.I) 2007.
- 9.5 The Trust will ensure that all staff working with vulnerable adults are appropriately trained in terms of adult protection work. Training will be



commensurate with the individual's role and responsibilities. In Regulated Services, requirements regarding adult protection training and refresher training will be complied with in keeping with Residential Home Regulations, Day Centre Regulations and Domiciliary Care Regulations. Reporting requirements in relation to regulated services will be strictly adhered to and RQIA procedures for reporting will be followed.

- 9.6 Safeguarding Vulnerable Adults Regional Policy and Procedural Guidance will be fully implemented.
- 9.7 In situations where alleged, suspected or confirmed abuse occurs the Trust will act promptly to protect the individual and to investigate the abuse.
- 9.8 Principles around consent and capacity will be adhered to and DHSSPS Guidance regarding consent and capacity will be applied.
- 9.9 Any decision taken regarding the possibility of overriding consent will be carefully assessed and a clear rationale for overriding consent will be required.
- 9.10 Human rights legislation will be considered in all cases and the rights of the individual will be recognised as of paramount importance.
- 9.11 The Trust will avoid unnecessary or premature initiation of a vulnerable adult investigation.
- 9.12 In situations where an alleged perpetrator is a Trust employee, all actions necessary to protect the vulnerable adult will be taken. This will include consideration of disciplinary procedures, with particular reference to precautionary suspension or change of duties while the investigation is being conducted.
- 9.13 In all situations involving Trust employees (or paid carers), consideration will be given to referral to the Independent Safeguarding Authority. DHSSPS Guidance on Vetting and Barring will be applied.
- 9.14 In all situations involving Trust employees, consideration will be given to whether referral to the person's professional body is appropriate.
- 9.15 Where a crime is suspected, referral on to PSNI will be made by Trust.
- 9.16 The Trust will work in partnership with the vulnerable adult, carers and relevant others.
- 9.17 Multi-disciplinary and multi-agency working are recognised as key aspects of the work and the Protocol for Joint Investigating of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009) will be implemented where applicable.
- 9.18 All services commissioned by the Trust are expected to report concerns regarding abuse of vulnerable adults to the relevant Service Group within the Trust. Regulated services must comply with the Residential Home Regulations, Domiciliary Care Regulations and Day Care Regulations.

- 9.19 Services commissioned by the Trust are required to comply with legislative requirements and regional policies, procedures and protocols. Furthermore, commissioned services must have in place adult protection arrangements that are compatible with the Belfast Trust's adult protection arrangements.
- 9.20 Standardised recording and monitoring systems will be put in place.
- 9.21 Annual audits will take place to ensure compliance with the Trust's obligations in relation to Statutory Functions.

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## 10. Implementation

This Policy should be implemented by all Service Groups and all staff are required to comply with the Policy & Procedures. In order to ensure effective implementation the Belfast Trust has in place a Learning & Development Adult Protection training strategy. This strategy recognises that Trust staff are required to be aware of the policies and procedures in relation to Adult Protection work and their role and responsibilities within this. Staff need to be trained to a level commensurate with the responsibilities of their post.

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An extensive training programme has been developed to ensure staff are provided with the necessary knowledge and skills to deliver, in terms of the obligations under the Adult Protection Policy.

The training programme consists of 5 levels of training:

### Level 1 Awareness Raising Training – half day course

Mandatory for all Trust staff working with vulnerable adults. This session focuses on the alert stage of the policy. In addition and in keeping with Residential Homes regulations, Domiciliary Care regulations and Day Care regulations, refresher training is provided to all staff working in regulated service every 2 years.

### Level 2 Training – one day course

Is aimed at first line managers and others who may be directly involved in the decision to refer to a Designated Officer (screening stage).

### Level 3 Designated Officer/Investigating Officer Training - 2 day course

For staff who are directly involved in the investigation and management of adult protection work.

### Level 4 Joint Protocol Training – 3 day course

Focuses on the Joint Agency Protocol. Joint PSNI and Trust training.

### Achieving Best Evidence Training – 8 day course

Joint PSNI and Trust training.

In addition to training, implementation will also be supported by work of the Belfast Area Adult Protection Forum. To ensure ongoing development and support to staff working directly in the Adult Protection field, good-practice groups will be established.

## 11. Sources / evidence base

'Safeguarding Vulnerable Adults Regional Adult Protection Policy & Procedural Guidance' 2006

'Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' July 2009

**12. References, including relevant external guidelines**

Law Commission for England and Wales (1995) Mental Incapacity Report No. 231  
London HMSO (1)

Guidance on Abuse of Vulnerable Adults (Management Executive Department of  
Health and Social Services 1996) (2)

Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural  
Guidance (2006) (3)

Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of  
Vulnerable Adult (July 2009) (4)

**Appendix 1****Procedures in relation to Adult Protection**

In keeping with Safeguarding Vulnerable Adults Policy & Procedural Guidelines 2006, the Belfast Health & Social Care Trust recognises that the process of dealing with an allegation or suspicion of abuse of a Vulnerable Adult goes through a number of distinct stages.

The Regional Policy has identified these as:

- Alerting.
- Referring.
- Screening.
- Planning the investigation.
- Investigating.
- Making decisions.
- Monitoring and review.

The Belfast Trust Policy & Procedures seeks to provide staff with a clear understanding of their roles and responsibilities at each of these stages. It also recognises that it will not always be necessary to follow through all of these stages in every case.

**1.1 Alerts**

All Trust staff have a responsibility to be alert to the possibility of abuse and in situations where they have concerns to report this immediately to their Line Manager. This duty to report alleged, suspected or confirmed abuse is absolute.

If the allegations relate to another Trust employee, the staff member should alert their line manager. If the allegations relate to the Line Manager, the staff member should report the matter to a more Senior Manager. It should be noted that the Public Interest Disclosure (Northern Ireland) Order 1998 provides for the active safeguarding and protection of what are commonly known as 'whistle blowers'. Reference should be made to the Belfast Trust Whistle Blowing Policy 2008.

Staff who fail to report concerns regarding abuse may be in breach of their contractual obligations and could be subject to Trust Disciplinary procedures and sanctioned by their professional bodies, i.e. Nursing & Midwifery Council, Northern Ireland Social Care Council.

Concerns regarding suspected abuse by Trust staff who work in regulated facilities should also be reported to Regulation Quality Improvement Authority as outlined in RQIA Procedures for Responding to Allegations, Suspicions or Incidents of Abuse of Vulnerable Adults in Regulated Services (November 2007).

Referral to the Independent Safeguarding Authority should be considered in all cases where there are concerns that a paid staff member may be responsible for abuse of a Vulnerable Adult. If the allegation relates to a Trust member of staff, the line manager should report to their senior manager and a decision will be made regarding whether referral to the Independent Safeguarding Authority is appropriate. Reference should be made to the DHSSPS guidance on referral to Independent Safeguarding Authority, (October 2009).

Services commissioned by the Trust are required to notify the Trust of any concerns regarding alleged, suspected or confirmed abuse. In addition, commissioned services are required to meet the reporting obligations in terms of referral to the Independent Safeguarding Authority.

In case of suspected abuse, the Line Manager should check that the Vulnerable Adult's immediate needs are being met, i.e. that there is no immediate danger and if required prompt medical assistance/assessment must be sought. If the Vulnerable Adult is in immediate danger, urgent action to protect the individual should be taken.

The Line manager, along with the member of staff should determine whether the issue requires a consultation with a Designated Officer.

In situations where a consultation with Designated Officer does take place, consideration will be given to involving the vulnerable adult or carer if appropriate.

Where there is a difference of opinion between the line manager and staff member or where more guidance is required as to whether an investigation should be pursued, the Line Manager should consult with the appropriate Designated Officer. In urgent cases, in the absence of the line manager, the member of staff should not delay the reporting of the incident and should contact a senior manager to discuss their concerns by telephone or in person.

All cases of suspected, alleged or confirmed abuse should be recorded on the VA1 form by the reporting staff member in conjunction with their line manager (Appendix 3). Should the line manager make the decision that there is no further action to be taken under the Adult Protection Policy, the VA1 form should be completed and filed in the client's records. A copy of the VA1 form should be forwarded to the appropriate senior manager within four weeks of the original referral.

The appropriate Senior Manager will collate and review the VA1 forms which have been screened out under the procedures to satisfy him or herself that actions taken are appropriate. The appropriate Senior Manager will provide a crucial role in terms of identifying possible patterns or trends. In situations where two or more VA1 forms have been screened out in relation to the same client or facility, consideration will be given to whether collectively this information warrants further investigation under Adult Protection Procedures.

### 1.2 Referral

Each Service Group will have their own complement of Designated Officers and Investigating Officers and a central register of Designated Officers is included in Appendix 5. Each service group must ensure that staff are kept updated re changes to this Register.

Cases concerning alleged, suspected or confirmed abuse should be referred to the appropriate Designated Officer. This contact can be made by telephone in first instance and should be confirmed in writing or electronically by the referrer within 2 working days on a VA 1 form (Appendix 3). On receipt of the VA1 form the Designated Officer will acknowledge the Trust referral within two working days on a VA3 form (Appendix 3).

Each Service Group will have a system in place to respond to referrals/consultations. All initial information provided by the referrer will be recorded on a VA2 form by the relevant Designated Officer/Investigating Officer/Duty Officer (Appendix 3).

The Designated Officer in consultation with the referrer should screen/ assess available information to:

- Establish the substance of the suspected, alleged or known abuse.
- Confirm that the individual falls within the scope of the Policy.

It is also important that the person's Human Rights are considered. Unnecessary or premature initiation of a Vulnerable Adult investigation should be avoided.

It is important to consider issues of consent and capacity in order to establish the individual's ability to give meaningful consent to the abusive act or situation or to any further investigative process. DHSSPS guidance in relation to Good Practice in Consent should be followed when determining the individual's capacity and ability to consent. There will be some circumstances in which it will be necessary to override the wishes of an individual, even though they are deemed to be capable of giving meaningful consent. This occurs when:

- there is an overriding public interest or justification for doing so, i.e. a risk to a child
- a significant risk of death or serious harm to the vulnerable adult and/or others
- a serious criminal offence is suspected.

Each referral should be assessed by the Designated Officer to determine the degree of risk and level of urgency in terms of response. Certain high risk situations will require an immediate response by Trust staff.

*Examples of such a situation would include responding to need for medical assistance and/or referral to PSNI. Staff should be aware of the need to preserve critical forensic evidence in certain circumstances, i.e. where there is an allegation of sexual abuse.*

In all other circumstances allegations of abuse should be subject to initial screening/investigation within 3 working days.

Any incidents arising outside normal office hours in the community/hospital/ Care facility and requiring immediate intervention should be referred to the Emergency Duty Team (Out of Hours Social Work Team).

The Emergency Duty Team should give priority to the protection of the vulnerable person. They should also advise on any immediate investigative actions that are required such as referral to PSNI or preservation of forensic evidence. The EDT must also report to the appropriate Designated Officer at the earliest opportunity when offices re-open.

All cases of alleged, suspected or confirmed abuse occurring within hospital settings, including Accident & Emergency, should be referred to the line manager and, if necessary, the hospital Designated Officer (senior social worker) during office hours. The hospital Designated Officer will then liaise with the appropriate community Designated Officer to agree who will take the lead role. Alleged or suspected cases of abuse which occur within the hospital setting out of hours must be reported to the senior manager on duty within the hospital and to the Emergency Duty Team (Out of

Hours Social Work Service) (see section 1.8 for more details regarding procedural requirements in relation A&E / hospital patients)

RQIA must be notified in all situations where concerns have arisen in a regulated service or a commissioned regulated service. The RQIA's Procedure for Responding to Allegations, Suspicions or Incidents of Abuse of Vulnerable Adults in Regulated Services (Nov 2007) must be followed. This requires that RQIA are notified immediately of any alleged, suspected or confirmed incidents of abuse within any service it regulates, by the appropriate line manager and Designated Officer. RQIA Incident Reporting Procedures should be followed.

The Designated Officer will ensure that all incidents of alleged, suspected or confirmed abuse in Care facilities (Statutory sector and Independent sector) or with Care Providers (Statutory and Independent) are reported to the relevant Service Group Manager or the Trust Quality Assurance Team.

With regard to referrals concerning allegations against staff and paid carers, the Trust will consider whether Disciplinary Procedures are appropriate. It will be the responsibility of the appropriate Line Manager to determine whether Disciplinary Procedures are required. If required, this will be conducted separately from any inquiry or investigation under the Adult Protection Policy, although there may be a need for simultaneous action and for the co-ordination of sharing of information. Action may include discussion with senior management regarding the precautionary suspension/relocation of staff.

Where a criminal investigation is taking place, the Trust must take no action which might interfere with the PSNI investigation. That said, consultation with PSNI should take place to determine whether an internal investigation can be conducted. It is recognised that Disciplinary Procedures in relation to staff may not be able to be concluded until a criminal investigation has been completed.

Where appropriate, staff will be reported to the relevant Statutory and other Bodies responsible for Professional Regulation; Northern Ireland Social Care Council, Nursing & Midwifery Council etc by the appropriate line manager.

Referrals to the Independent Safeguarding Authority must be considered in all cases where there are concerns that a paid staff member may be responsible for abuse of a Vulnerable Adult. DHSSPS guidance regarding referral criteria should be followed. If referral is deemed necessary, the relevant staff member's line manager should make this referral. Line Managers considering referral to the Independent Safeguarding Authority should follow service group arrangements regarding whether a Senior Manager and/or Human Resources should be consulted. This reporting requirement is applicable to both Trust services and all other services commissioned by the Trust.

### 1.3 Screening

The Designated Officer will make an initial judgement based on referral information regarding whether further investigation is appropriate. In some situations it may be evident from the outset that a full investigation is appropriate. In other situations a further screening may be required.

Where appropriate, the Designated Officer will allocate the referral to an Investigating Officer. The Investigating Officer will take the lead role in carrying out the investigation, as directed by the Designated Officer.

Possible outcomes of screening may be that:

- No further action is required.
- No further action under Adult Protection procedures is required but referral on for an appropriate assessment is required, e.g. for new or increased services, Carer's Assessment.
- Further screening under Adult Protection procedures is required.
- Full investigation under the Adult Protection Procedures is required.
- The Designated Officer will consider whether the Protocol for Joint Investigation of Alleged and Suspected Abuse of Vulnerable Adults is Relevant and refer to PSNI if appropriate.

Where there is a decision not to proceed, the Investigating Officer should consult with the Designated Officer. If the Designated Officer is satisfied with the Investigating Officer's assessment, the VA4 form will be signed by the Designated Officer and forwarded to the appropriate Senior Manager.

The appropriate Senior Manager will collate and review information received.

In all cases of alleged, suspected or confirmed abuse, the key priority will be to protect the vulnerable adult from further abuse. The protection planning should begin as soon as an allegation of abuse is made and will be a key consideration for the Designated Officer and the Investigating Officer at all stages in the investigation process.

#### **1.4 Planning the Investigation**

At the point of referral a Strategy Discussion will take place to ensure an early exchange of information and to clarify whether there is a need for any immediate action to be taken. The Strategy Discussion may take place by telephone but in particularly complex referrals, there may be a need for a Strategy Discussion meeting. Strategy Discussion via telephone should take place within one working day of referral to the Designated Officer, unless good practice dictates otherwise. A comprehensive record of the Strategy Discussion should be recorded on a VA4 if the discussion takes place by telephone or via minutes of meeting.

If as a result of information received at referral or from the Strategy Discussion, significant concerns emerge regarding very serious risk of harm or homicide from domestic violence, the Designated Officer should consider whether referral to the Multi Agency Risk Assessment Conference (MARAC) might be appropriate.

#### **Multi-Agency Risk Assessment Conference (MARAC)**

It should be noted that the main aim of the MARAC is to reduce the risk of serious harm by providing a forum for a co-ordinated Multi-Agency response to Protection Planning for the victims of domestic violence.

Each Service Group will have appointed a named MARAC Representative and all cases being considered under MARAC should be discussed and agreed with the Service Group MARAC Representative to establish whether the criteria for referral is met.



A specific Risk Identification checklist (CAADA) can be helpful when determining whether a referral to MARAC is appropriate but the professional judgement of the Designated Officer is of primary importance and may trigger a MARAC referral.

If a referral is considered appropriate, a MARAC referral form should be completed and forwarded to the service specific MARAC Representative and also the nominated PSNI MARAC Representative.

It must be stressed that MARAC offers an additional mechanism/forum to look at protection arrangements for a small number of vulnerable adults at very serious risk of harm but does not replace the need for protection and investigation under Adult Protection Procedures. In Adult Protection cases where a MARAC referral is deemed to be appropriate, MARAC will be used to enhance the protection planning process.

Following the Strategy Discussion and depending on the decisions made, the investigation may proceed through a single agency investigation, joint investigation with PSNI or joint investigation with other agencies.

- (a) Single Agency Investigations. These are investigations where intervention rests solely with one agency, e.g. Trust, PSNI.
- (b) Joint Investigations with the Police. A detailed consideration of the need for a joint investigation with the PSNI will be triggered when there is an allegation or suspicion that one of the following criminal offences has been committed against a Vulnerable Adult:
  - A sexual offence committed against a Vulnerable Adult. Allegations or suspected sexual abuse .
  - Physical abuse or ill-treatment amounting to a criminal offence.
  - Financial abuse involving a criminal offence such as fraud or theft.
  - Abuse which involves a criminal offence; e.g. blackmail.

}	Allegations should be reported to either the PSNI Rape Crime Unit or to the relevant PSNI Public Protection Unit..
}	Allegations should be reported to the appropriate PSNI Crime Unit.

Where a decision to proceed to joint investigation is taken, the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009 must be followed. Under this Protocol the Designated Officer should decide whether the grounds for Joint Agency Consultation are met. The Designated Officer should, if they suspect a crime has been committed, contact PSNI within 24 hours. As the referrer, the Designated Officer has a responsibility to complete the AJP1 form (Appendix 3), which is a record of the Joint Agency Consultation. The Designated Officer must send the original AJP1 to the PSNI and retain a copy on the client file.

In instances of abuse that constitute a criminal offence and where there is a decision that the Trust and PSNI will jointly investigate the incident, it must be remembered that only staff trained as Specialist Interviewers should conduct Achieving Best Evidence interviews.

- (c) Joint Investigations with Other Agencies. These are investigations

which involve more than one agency or organisation but which lie outside the 'Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults', e.g. Joint Investigations between Trust and Care Provider (see section 1.9).

Where the Vulnerable Adult receives a service from a registered establishment or agency (statutory, private and independent sector), the manager of the registered facility has a responsibility to inform RQIA of any ongoing investigation. The Designated Officer must also refer the matter immediately to the appropriate Inspector within RQIA, in keeping with RQIA Reporting Procedures.

Where care is being purchased by the BHSCT outside of the Trust area, the Care Provider must notify the relevant BHSCT staff of any allegations or suspicions of abuse and they in turn must notify the relevant Trust Designated Officer. The Care Provider must also notify their local Designated Officer. Close communication and co-ordination should take place between the relevant Designated Officer within the Belfast Trust (Commissioning Trust) and the relevant Designated Officer in the host Trust. The Belfast Trust, as the Commissioning Trust, will take the lead role in relation to their individual client, however if there is a wider protection issue the host Trust will take the lead role and involve the commissioning Trust as part of this process.

Where care is being purchased within the BHSCT by another Trust and an individual case of suspected, alleged or confirmed abuse occurs, the commissioning Trust will be responsible for investigation and protection planning in relation to their client. In cases where a wider protection issue has been identified, the host Trust will take the lead role in terms of co-ordination and overall management of the investigation.

The relevant Designated Officer will work in partnership with the relevant Care Provider to ensure that a full investigation is carried out and that Adult Protection Policy & Procedures are adhered to (see section 1.9 for more details regarding joint investigation between Trust and other agencies / providers).

### 1.5 Investigation

The Investigating Officer will take the lead role in carrying out the investigation and must keep the Designated Officer fully informed throughout the investigation process.

The Investigating Officer should ensure that the alleged victim is interviewed if appropriate and is fully involved in all decisions at all stages in the investigation process. In situations where this is not possible, i.e. significant cognitive impairment or severe learning disability, a carer, family member or advocate should be involved if appropriate. Interviews with the alleged victim and significant others should be recorded on VA5 forms (Appendix 3).

Careful consideration should be given to whether an alleged perpetrator will be interviewed. Staff should be mindful of the potential for aggression or violence. The Belfast Trust Policy 'A Zero Tolerance Approach to the Prevention and Management of Violence and Aggression in the Workplace 2008' is applicable. In certain circumstances to ensure the protection of staff, a range of measures will be looked at, i.e. two staff members being involved in interviews, venue of interviews, etc.

The Investigating Officer is required to carry out a Risk Assessment as part of the investigation and must complete a VA6 form (Appendix 3) or a Risk Assessment form which has been approved by their Service Group as suitable for Adult Protection Risk Assessment purposes.

In situations where the alleged perpetrator is also a vulnerable adult, referral on to another programme of care may be appropriate. If the alleged perpetrator is already known to another programme of care, close communication and co-ordination should take place to ensure that the needs of both clients are fully met.

### 1.6 Making Decisions

#### Case Conference / Case Discussions

A Case Discussion/Case Conference should be convened where appropriate and chaired by the Designated Officer as soon as possible and no later than 14 working days after the completion of the investigation. The purpose of the meeting is to identify risks and the actions necessary to manage these risks. Any interim protection plan should be reviewed and an appropriate protection plan must be agreed at this meeting.

A Minute of the Case Conference/Case Discussion should be taken. A VA7 form (Appendix 3) should be completed.

### 1.7 Care & Protection Planning / Monitoring / Review

The Vulnerable Adult should be fully involved in the drawing up of the care plan and where this is not possible a family member, carer or advocate should be involved if appropriate.

Consideration of whether the abuse constitutes a very serious risk of harm due to domestic violence should be kept under close review and referral to MARAC should take place if at any stage the investigation indicates that the MARAC criteria for referral is met.

The Designated Officer must ensure circulation of the care plan to the Vulnerable Adult, carer (if appropriate) and relevant others within three working days. The Trust VA7 (Appendix 3) care plan should be used.

In cases deemed to be of continued high risk, the situation should be closely monitored and the care plan reviewed within by the Investigating Officer and Designated Officer within 24 hours, or as required. The VA7 form should be updated to evidence this process (Appendix 3)

In all other cases the care plan should be reviewed with the vulnerable adult an/or relevant others within 10 days of implementation by the Investigating Officer. A VA7 form should be completed. W

Care plan should then be reviewed at three-monthly intervals (minimum) by the Investigating Officer. If there are significant concerns, the Designated Officer may formally review the Care Plan as part of a Case Conference. A VA8 form (Appendix 3) must be completed as a Minute of the Case Review meeting and a VA7 Care Plan. W

Decisions regarding transfer or closure of a case under the Adult Protection Procedures must be made in consultation with the vulnerable adult if appropriate and all relevant others. A VA9 form should be completed to evidence this process (Appendix 3)

### 1.8 Accident & Emergency / Hospital In-patients

- All hospital staff (doctors, nurses, radiographer, cleaners, etc.) should be alert to the possibility of abuse of Vulnerable Adults.
- Any concerns staff have should be reported immediately to their line manager, i.e. Ward Sister, Consultant, etc. Staff's obligation to report alleged, suspected or confirmed abuse is absolute and staff who fail to report concerns regarding abuse may be in breach of their contractual obligations and could be subject to Trust disciplinary procedures and sanctioned by their professional body, such as Nursing & Midwifery or NISCC.
- The Line Manager/Ward Manager, in consultation with the member of staff, will decide what actions need to be taken.
- It is recommended that the Line Manager/Ward Manager consults with the hospital Designated Officer/Senior Social Worker if they are in any doubt as to whether an issue falls within the scope of the Adult Protection Policy.
- It is recognised that these consultations will mainly be by phone, except in very complex cases where a strategy meeting may be required.
- The hospital Designated Officer should record all information provided via telephone referrals on a VA2 form (Appendix 3).
- The hospital Designated Officer will review available information in conjunction with the referrer and will make the decision as to whether further investigation under the Adult Protection Policy is required.
- Not all consultations with the hospital Designated Officer will result in an investigation but in situations where concerns have been raised, the referrer should complete a VA1 form (Appendix 3) and forward this to the Designated Officer within two working days of referral. On receipt of a referral the Designated Officer will acknowledge the referral in writing within two working days on a VA3.
- In all cases of alleged, suspected or confirmed abuse when a crime is suspected the Designated Officer will consult with the relevant Police Liaison Officer. Through the Joint Agency Consultation Process a decision will be made as to who is best placed to take forward a Vulnerable Adult investigation.
- The Protocol for Joint Investigating of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009) must be strictly adhered to.
- In situations where the Trust are conducting the investigation and the abuse relates to an incident occurring within a hospital setting, the hospital Designated Officer will take the lead role. In all other cases the hospital Designated Officer will immediately link with the Community Designated Officer and consideration will be given to who is best placed to take on the management responsibility for the investigation.

See sections 9.2 to 9.7 for roles and responsibilities of Designated Officer and Investigating Officer,

If the allegation relates to a Vulnerable Adult who is resident in a regulated Care facility (Residential, Nursing, EMI, Statutory, Voluntary), the hospital Designated Officer should notify the host Trust and if necessary the commissioning Trust, Care Home and RQIA of the allegation. RQIA procedures must be followed.

Where the concern or allegation relates to a Vulnerable Adult known to Mental Health Service or Learning Disability Programme of Care, the hospital Designated Officer should inform RQIA when an investigation is initiated and also of the eventual outcome.

Appropriate Care & Protection arrangements must be in place before discharge of the patient to the community.

### Immediate Concerns

If there is an immediate concern for the safety and well being of a patient because of an incident which has occurred on the hospital site, the Line Manager/Ward Manager should immediately:

1. Ensure that the patient is in no imminent danger and that he/she is protected from harm and his/her needs are being met, i.e. Security and/or PSNI maybe required.
2. Refer to the hospital Designated Officer, who will then take the lead role in terms of managing the investigation.
3. Inform the appropriate Assistant Service Manager/Senior Manager.

The Designated Officer, in consultation with the Assistant Service Manager/Senior Manager, will decide whether PSNI need to be contacted.

If there is an immediate concern for the safety and well being of a patient **outside of office hours**, the Ward Manager or senior member of staff on duty should immediately:

1. Ensure patient's immediate protection.
  2. Seek guidance and direction from senior manager on site (Patient Flow co-ordinator).
- The Patient Flow Co-ordinator, as the senior manager on site, should assess available information and determined whether he/she is competent to deal with the issue or needs to refer this on to a more senior manager.
  - The senior manager on site/Senior Manager on call should assess available information and determine whether the situation falls under the Adult Protection Policy & Procedure. If there is any concern or doubt regarding whether the incident falls under the remit of the procedures, a consultation via telephone with the Emergency Duty Team's Designated Officer should take place.
  - The patient's health, safety and well being are key priorities and responsibility for this rests clearly with hospital staff.
  - The Emergency Duty Team's role in such cases will be to provide access to a Designated Officer who will support and assist the senior manager on duty.

- The Emergency Duty Team's Designated Officer's role and responsibility is as outlined in section 1.2 to 1.7. That said, it is recognised that as an Out-of-Hours Service, only priority issues will be addressed, i.e.: consideration must be given to whether PSNI need to be involved. If a crime is suspected there should be no delay in reporting concerns to PSNI. It should be remembered that vulnerable adults may require assistance when being interviewed by the Police. The Emergency Duty Team will facilitate access to a Specialist Interviewer if PSNI wish to conduct an interview.
- All Adult Protection cases arising out of hours must be reported to the relevant Designated Officer as soon as possible. In most situations it is anticipated that the relevant Designated Officer will then take responsibility for carrying forward the Adult Protection work.

### **1.9 Joint Investigations between Trust and other Agencies /Care Providers**

- Care Providers are required to be alert to the possibility of alleged, suspected or confirmed abuse of vulnerable adults and to report concerns immediately to their Line Manager.
  - All concerns must be brought to the attention of the Registered Manager. The Registered Manager must report all concerns regarding alleged, suspected or confirmed abuse to RQIA, in keeping with RQIA reporting procedures.
  - The Registered Manager/Line Manager should report any concerns either directly to the relevant Designated Officer or to the staff member within the Trust who commissioned the service.
  - Where concerns are reported to a staff member within the Trust, available information should be assessed to determine whether a referral to the relevant Trust Designated Officer is appropriate.
  - A consultation with the Designated Officer should take place if there is any doubt regarding whether a referral is appropriate, or where there is a difference of opinion regarding referral.
  - The Designated Officer will screen available information and determine whether an investigation under Adult Protection Procedures is required. The Designated Officer should record referral information, along with the Screening Outcome, on a VA2 form (Appendix 3)
  - The Designated Officer has overall responsibility for ensuring that a full investigation is carried out and that an appropriate Protection Plan is in place.
- 
- The relevant Designated Officer will work in partnership with the relevant Care Provider to ensure that a full investigation is carried out and that an appropriate Protection Plan is in place.
  - The Care Provider must ensure the protection of the vulnerable adult and consider whether there are risks to any other vulnerable adults. The Care

Provider must discuss and agree the interim protection plan with the Designated Officer on the same day as the referral.

- If the Designated Officer has concerns regarding the interim protection plan, the Care Provider should revisit this plan and put forward alternative proposals.
- In the unlikely event that the Designated Officer and Care Provider cannot agree on the interim protection plan, a same-day consultation with RQIA should take place.
- The Designated Officer will appoint an Investigating Officer.
- The Designated Officer will co-ordinate the Strategy Discussion/Meeting and agree roles and responsibilities within the investigation. A VA4 Strategy Discussion form should be completed (Appendix 3)
- In relation to allegations of abuse by a staff member, the Registered manager must consider whether referral to the Independent Safeguarding Authority is appropriate.
- If required, it is the responsibility of the Registered Manager/Care Provider to make the referral to the Independent Safeguarding Authority. Copies of the Independent Safeguarding Authority report should be forwarded to the relevant Designated Officer.
- Consideration should also be given to whether referral to the staff member's professional body is appropriate, i.e. NISCC. Responsibility for this rests with the Employer/Care Provider.
- Depending on the nature and seriousness of the allegation, the Designated Officer may need to involve the PSNI and consideration will be given to whether the Protocol for Joint Investigation of Alleged, Suspected cases of Abuse of Vulnerable Adults (2009) is applicable.
- As a minimum all investigations should involve interviews with the Vulnerable Adult and alleged perpetrator. In situations where a crime is suspected, a consultation.
- The standard investigation will include the Investigating Officer interviewing the vulnerable adult and the Care Provider interviewing the staff member against whom the allegation has been made.
- Depending on the complexity of the allegation, wider screening interviews of other service users by the Investigating Officer and interviews of other staff by Care Providers may need to take place.
- In exceptional circumstances, the Designated Officer may consider that the Trust should conduct the full investigation, which would include interviews with staff, i.e. institutional abuse where the Agency cannot provide an independent investigator.
- Both the Investigating Officer and the Registered Manager/Care Provider will be required to provide reports regarding the outcome of their investigation.



- The Designated Officer will convene a Case Discussion/Discussions as required and the final outcome of the investigation will be discussed and agreed at this meeting. The Designated Officer will record decisions made on a VA7 form (Appendix 3). The protection plan will be reviewed and decisions made regarding ongoing monitoring and review.

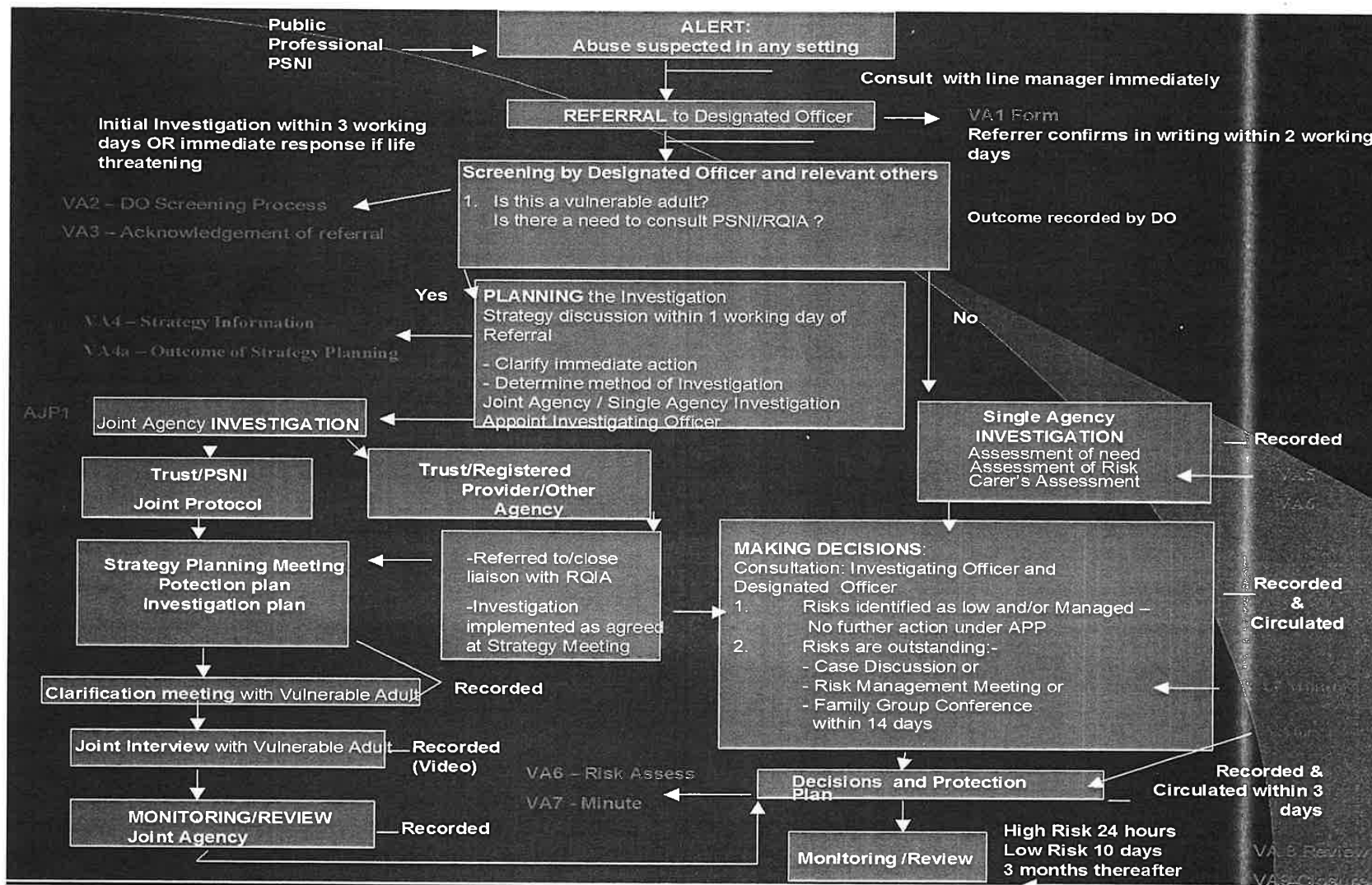
#### **1.10 Direct Payments**

Where a Direct Payment is in place, clients and their carers should be made aware of the arrangements for the management of adult protection in their area. Such service users should receive the same level of support and protection as any other vulnerable adult if abuse occurs. Any concerns should be reported in the first instance to the Trust representative, i.e. Care Manager, Social Worker, who in turn will link with the relevant service group to initiate Adult Protection procedures.

**A P P E N D I C E S**

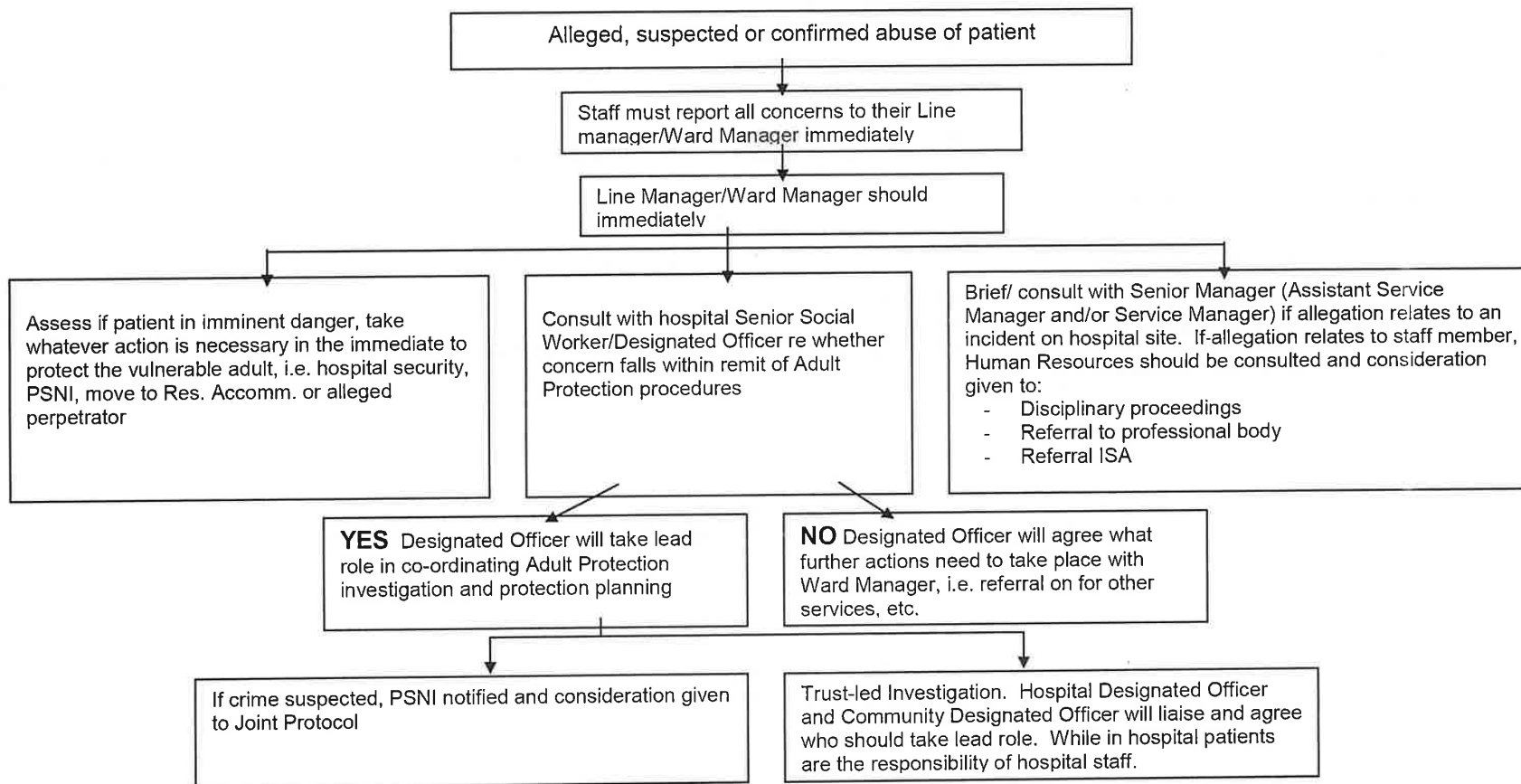
**Overview of Adult Protection Procedure**

Appendix 2.1



**HOSPITAL SETTING**

**Reporting Procedures for Responding to Vulnerable Adult Abuse Concerns**



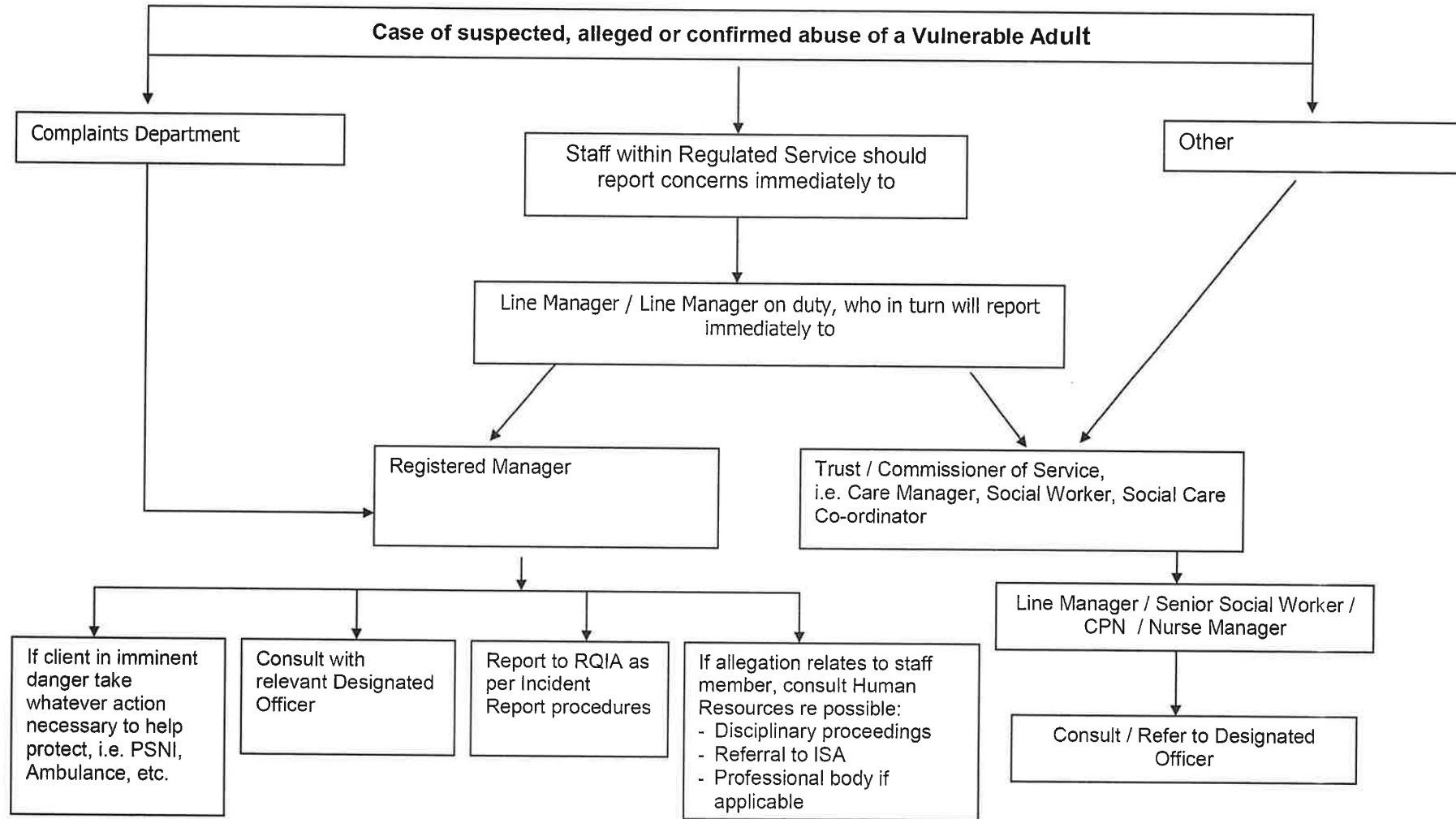
**Out of Office Hours**

\* Designated Officer is contactable via Emergency Duty Team – tel: 9056 5444

\* Senior Manager on site and/or Senior Manager on-call to be notified if incident relates directly to incident occurring in hospital setting

**REPORTING PROCEDURES RE TRUST REGULATED SERVICES**

(Residential, Domiciliary, Day Care Services)





**BELFAST HEALTH & SOCIAL CARE TRUST**

**RECORDING DOCUMENTATION IN RELATION TO ADULT  
PROTECTION PROCEDURES**

- VA1 Alert / Referral
- VA2 Designated Officer Screening Process
- VA3 Acknowledgement of Referral under Protection of Vulnerable Adults Policy & Procedures

**Planning the investigation**

- VA4 Initial Information Gathering – Strategy Information
- VA4a Outcome of Strategy Planning

**Investigation Process**

- VA5 Significant Interview / Event Report – Investigation Process
- VA6 Investigating Report / Assessment of Risk
- VA6a Protection Plan

**Making Decisions**

- VA7 Minutes of Strategy Meeting / Case Discussion / Review
- VA8 Review of Care / Protection Plan
- VA9 Closure / Transfer Summary

**BELFAST HEALTH AND SOCIAL CARE TRUST**  
**PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS FROM ABUSE AND**  
**EXPLOITATION**

**ALERT / REFERRAL**

**\* THIS FORM IS FOR INFORMATION KNOWN BEFORE AN INVESTIGATION COMMENCES. DO NOT ASK SERVICE USER INVESTIGATIVE QUESTIONS IN ORDER TO COMPLETE THIS FORM \***  
*(SECTION 1 & 2 TO BE COMPLETED BY REFERRER) SHOULD BE COMPLETED WITHIN 2 WORKING DAYS OF INITIAL REFERRAL*

<b>SECTION ONE: BACKGROUND INFORMATION</b>		
<b>NAME:</b>  <b>ADDRESS:</b>  <b>CURRENT LOCATION:</b>	<b>NOK CONTACT DETAILS:</b>	<b>DATE OF BIRTH:</b>  <b>GENDER: M <input type="checkbox"/> F <input type="checkbox"/></b>
<b>TELEPHONE NO:</b>	<b>COMPUTER NUMBER:</b>	<b>GP: ADDRESS:</b>  <b>TEL. NO:</b>
<b>OTHER PROFESSIONALS INVOLVED:</b>		
<b>ETHNIC ORIGIN</b> <i>(PLEASE TICK APPROPRIATE BOX)</i>  <input type="checkbox"/> WHITE <input type="checkbox"/> CHINESE <input type="checkbox"/> BLACK <input type="checkbox"/> INDIAN <input type="checkbox"/> TRAVELLER <input type="checkbox"/> UNKNOWN <input type="checkbox"/> REFUSED <input type="checkbox"/> NOT COMPLETED <input type="checkbox"/> OTHER <i>(PLEASE SPECIFY)</i> _____		
<b>SERVICE GROUP</b> <i>(PLEASE TICK APPROPRIATE BOX)</i>  <input type="checkbox"/> OLDER PEOPLE <input type="checkbox"/> LEARNING DISABILITY <input type="checkbox"/> PHYSICAL DISABILITY <input type="checkbox"/> MENTAL HEALTH <input type="checkbox"/> SENSORY DISABILITY <input type="checkbox"/> OTHER <i>(PLEASE SPECIFY)</i> _____		
<b>IS THE ADULT SUBJECT TO ANY LEGAL/STATUTORY STATUS ?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> N/K <input type="checkbox"/>  <i>IF YES, PLEASE SPECIFY:</i> _____		
<b>SECTION TWO: INFORMATION ON THE SUSPECTED OR CONFIRMED ABUSE</b>		
<b>WHO WAS THE FIRST PERSON TO NOTE THE CONCERN?</b> <b>NAME:</b> _____ <b>DATE:</b> _____ <b>CONTACT NO:</b> _____		
<b>DOES THIS PERSON WANT TO REMAIN ANONYMOUS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <i>IF SO, WHY?</i>		
<b>WHERE DID THE SUSPECTED, ADMITTED OR KNOWN ABUSE OCCUR? (SPECIFY LOCATION)</b>		



<input type="checkbox"/> PERSONS HOME	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> NURSING HOME / RESIDENTIAL HOME	<input type="checkbox"/>
COMMUNITY			
<input type="checkbox"/> DAY CARE FACILITY (SPECIFY) _____			
<input type="checkbox"/> SUPPORTED LIVING FACILITY (SPECIFY) _____		<input type="checkbox"/> OTHER	

<b>VA1</b>		
<b>NAME AND ADDRESS OF THE PERSON ALLEGEDLY RESPONSIBLE FOR THE SUSPECTED OR KNOWN ABUSE.</b>		
<b>NAME:</b>	<b>ADDRESS:</b>	<b>DATE OF BIRTH:</b> IF NOT KNOWN, PLEASE GIVE APPROXIMATE AGE:
	<b>TELEPHONE NO:</b>	<b>GENDER: M <input type="checkbox"/> F <input type="checkbox"/></b>

**RELATIONSHIP TO THE SERVICE USER: (PLEASE TICK APPROPRIATE BOX)**

<input type="checkbox"/> PARTNER	<input type="checkbox"/> FAMILY MEMBER (SPECIFY) _____
<input type="checkbox"/> NOT KNOWN TO CLIENT	<input type="checkbox"/> TRUST PROVIDER SERVICE
<input type="checkbox"/> TRUST STAFF	<input type="checkbox"/> OTHER SERVICE USER
<input type="checkbox"/> AGENCY STAFF	<input type="checkbox"/> OTHER (SPECIFY) _____

**IS THE PERSON WHO IS ALLEGEDLY RESPONSIBLE?**

A VULNERABLE ADULT YES  NO  N/K

IN RECEIPT OF SERVICES YES  NO  N/K

A CHILD YES  NO  N/K  IF YES, HAS A UNOCINI BEEN COMPLETED? YES  NO

HAS THE GATEWAY BEEN CONTACTED? YES  NO

**ARE THERE OTHER VULNERABLE ADULTS / CHILDREN AT RISK OF ABUSE IN THIS SITUATION?**  
YES  NO  N/K  IF YES, NOTE THEIR NAMES AND WHO THE REFERRAL WAS MADE TO

NAME _____	REFERRED TO _____
DATE _____	
NAME _____	REFERRED TO _____
DATE _____	

**WHAT IS THE MAIN FORM OF SUSPECTED, ADMITTED OR KNOWN ABUSE?**  
(Place an 'X' in the box of the abuse that triggered the alert and tick all other abuse that is also relevant to this case)

<input type="checkbox"/> PHYSICAL	<input type="checkbox"/> SEXUAL	<input type="checkbox"/> PSYCHOLOGICAL/EMOTIONAL
<input type="checkbox"/> FINANCIAL	<input type="checkbox"/> NEGLECT	<input type="checkbox"/> INSTITUTIONAL ABUSE
<input type="checkbox"/> DISCRIMINATION	<input type="checkbox"/> OTHER (PLEASE SPECIFY)	

**PLEASE GIVE EXACT DETAILS OF WHAT HAS BEEN REPORTED AND IF APPROPRIATE, NOTE INJURIES ON THE ATTACHED BODY CHART.**

**HAVE THERE BEEN PREVIOUS CONCERNS OR EVIDENCE OF ABUSE TO YOUR KNOWLEDGE?**  
YES  NO  N/K  IF YES, WHAT WAS THE NATURE OF THE CONCERN AND THE OUTCOME.

<b>NAME OF LINE MANAGER NOTIFIED:</b> _____ <b>DATE:</b> _____ IF THE LINE MANAGER / DESIGNATED OFFICER IS NOT IMMEDIATELY AVAILABLE AND IT IS AN EMERGENCY, CONTACT THE NEXT SENIOR MANAGER OR THE EMERGENCY DUTY TEAM (90565444)	
<b>WHAT ARE THE SERVICE USERS VIEWS? (NOTE WHETHER THE PERSON VIEWS THE SITUATION AS ABUSIVE AND HOW THEY WANT THE TRUST TO RESPOND)</b>	
VA1 <b>IS THE SERVICE USER AWARE THAT AN INVESTIGATION MAY NOW TAKE PLACE?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> N/K <input type="checkbox"/>	
<b>CAN THE PERSON UNDERSTAND THE INFORMATION OR GIVE CONSENT TO AN INVESTIGATION?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> N/K <input type="checkbox"/>	
<b>HAVE THEY GIVEN CONSENT FOR YOU TO CONTACT RELEVANT OTHERS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> N/K <input type="checkbox"/> (IF CONSENT IS NOT AGREED CONSULT WITH LINE MANAGER/DESIGNATED OFFICER)	
<b>NOTE THE NAMES AND VIEWS OF OTHERS YOU HAVE CONSULTED, ANY ACTION TAKEN AND THE OUTCOME (PLEASE NOTE ANY DIFFERENCES IN OPINION OR IF MORE GUIDANCE / INFORMATION IS REQUIRED)</b>	
<b>SIGNATURE:</b> _____ <b>DATE:</b> _____	
<b>SECTION THREE: OUTCOME OF INTIIAL SCREENING</b> (TO BE COMPLETED WITH LINE MANAGER / DESIGNATED OFFICER)	
<b>DECISION TAKEN BY LINE MANAGER / MEMBER OF STAFF:</b>	
REFERRAL TO DESIGNATED OFFICER <input type="checkbox"/> NAME _____ ADDRESS _____ TEL. NO. _____	
<p><b><u>(TWO OR MORE VA1 RECORDS THAT HAVE NOT PROCEEDED TO INVESTIGATION MAY INDICATE A NEED FOR A CASE DISCUSSION AT LOCAL LEVEL OR REFERRAL TO DESIGNATED OFFICER).</u></b></p>	
<b><u>ARE OTHER IMMEDIATE ACTIONS REQUIRED</u></b>	
FURTHER ASSESSMENT REQUIRED	YES <input type="checkbox"/> NO <input type="checkbox"/>
NOTIFY QUALITY MONITORING OFFICER	YES <input type="checkbox"/> NO <input type="checkbox"/>
PSNI CONTACT	YES <input type="checkbox"/> NO <input type="checkbox"/>
PROFESSIONAL BODIES INFORMED	YES <input type="checkbox"/> NO <input type="checkbox"/>
IMMEDIATE PROTECTION PLAN IMPLEMENTED	YES <input type="checkbox"/> NO <input type="checkbox"/>
OTHER TRUSTS INFORMED	YES <input type="checkbox"/> NO <input type="checkbox"/>
NOTIFY RQIA	YES <input type="checkbox"/> NO <input type="checkbox"/> SPECIFY WHO _____
_____ NO FURTHER ACTION UNDER SVA POLICY <input type="checkbox"/> STATE REASON _____	

<b><u>SIGNATURE</u></b>	<b><u>DATE</u></b>
<b><u>SIGNATURE OF LINE MANAGER</u></b>	<b><u>DATE</u></b>

**Referral to the Designated Officer:**  
 Forward the VA1 to the Designated Officer within two working days.

**Referral to Other Agency or Department:**

Forward the VA1 or other appropriate report

**No referral:**

File VA1 on the persons file and notify the central data base.

VA2

BELFAST HEALTH AND SOCIAL CARE TRUST

PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS FROM ABUSE AND EXPLOITATION

DESIGNATED OFFICER SCREENING PROCESS

<b>FULL NAME:</b>	<b>DATE OF REFERRAL:</b>
<b>ADDRESS:</b>	<b>N.O.K: ADDRESS:</b>
<b>TEL. NO:</b>	<b>TEL. NO:</b>
<b>D.O.B</b>	
<b>SERVICE GROUP: PHY DIS</b>	<b>COMPUTER NUMBER:</b>
<b>Is the service user a vulnerable adult as defined by the safeguarding vulnerable adults policy?</b>	<b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>

1A DETAILS OF REFERRER (the person who brings the concerns to the attention of your agency)	
<b>Name:</b>	<b>Relationship to service user:</b>
<b>Job title and agency:</b>	
<b>Contact number:</b>	
<b>If the referrer wishes to remain anonymous, please tick here</b>	<b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>
<b>Has it been explained that anonymity may limit the investigation?</b>	<b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>
<b>Is the service user aware that the report is being made?</b>	<b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>

	<b>Name</b>	<b>Address &amp; Tel. No.</b>
<b>Key Worker</b>		
<b>Care Manager</b>		
<b>G.P</b>		
<b>Other</b>		
<b>FAMILY/CARER</b>		
<b>SIGNIFICANT OTHER</b>		

2.A PLEASE STATE THE NATURE OF THE ALLEGED ABUSE		
<b>PHYSICAL</b> <input type="checkbox"/>	<b>SEXUAL</b> <input type="checkbox"/>	<b>INSTITUTIONAL ABUSE</b> <input type="checkbox"/>
<b>FINANCIAL</b> <input type="checkbox"/>	<b>NEGLECT</b> <input type="checkbox"/>	<b>PSYCHOLOGICAL</b> <input type="checkbox"/>
<b>DISCRIMINATION</b> <input type="checkbox"/>	<b>OTHER</b> <input type="checkbox"/>	

VA2

<b>2.B INCIDENT REPORT</b>	
<b>Please provide us with a description of the alleged abuse</b>	
Background information:	
<b>INCIDENT REPORT – LOCATION / DATE / TIME OF INCIDENT</b>	

<b>2.C THE SERVICE USER'S USUAL LIVING ARRANGEMENTS</b>	
Does service user live alone?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does alleged abuser live with service user?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is service users present location different from home address?	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>3. HAVE YOU TAKEN ANY ACTION DUE TO EMERGENCY SITUATION TO AVOID IMMEDIATE SERIOUS RISK?</b>	
Was immediate protection needed for Service User:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Detail:	
Was immediate protection taken for others in the vicinity?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Detail:	

VA2

4. SERVICE USER'S KNOWLEDGE OF REFERRAL	
Does person know that a referral has been made?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>

5. DETAILS OF ALLEGED PERPETRATOR		
Name:		
Address:	Date of birth:	
	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
	Postcode	
Does the alleged perpetrator know that an allegation has been made against them?		Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
Is alleged perpetrator known to service user? Please specify:		Yes <input type="checkbox"/> No <input type="checkbox"/>
Family member <input type="checkbox"/>	Another service user <input type="checkbox"/>	Paid carer <input type="checkbox"/>
Trust employee <input type="checkbox"/>	Other <input type="checkbox"/>	

ANY ADDITIONAL INFORMATION RELEVANT TO THE REFERRAL

AGREED ACTION	
FURTHER SCREENING REQUIRED BY REFERRER	<input type="checkbox"/>
ALLOCATE TO INVESTIGATING OFFICER FOR SCENING/INVESTIGATION	<input type="checkbox"/>
NO FURTHER ACTION UNDER SVA POLICY <u>Please state reasons</u>	<input type="checkbox"/>
OTHER <u>Please state reasons</u>	<input type="checkbox"/>
ALLOCATE TO:	
NAME:	DATE:

REFERRAL TAKEN BY:	
NAME:	DATE:
SIGNATURE OF DESIGNATED OFFICER:	DATE:

## BODY MAP

Name of vulnerable person

Name of person completing this form

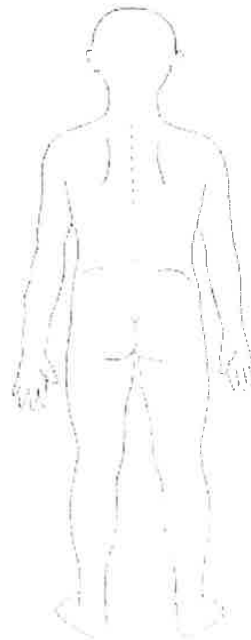
These diagrams are designed to help you record any visible signs of harm or injury. Shade and label any bruises, cuts, burns, and so on. Label any parts of the body where any internal injuries have been identified as a result of a medical examination. If injuries are evident in soft-tissue parts of the body, such as the neck, under-arms, stomach, genitals or inner thighs, these are unlikely to have occurred as a result of a fall or accident.

Do not worry if this information is not available at this stage, it can be documented as part of the investigation, if that is more appropriate.

Front



Back



Face



VA3

**BELFAST HEALTH & SOCIAL CARE TRUST**

**ACKNOWLEDGEMENT OF REFERRAL UNDER PROTECTION OF VULNERABLE ADULTS POLICY AND PROCEDURES**

To be completed by the Designated Officer and returned to referrer within 2 days

<b>NAME:</b>  	<b>ADDRESS:</b>  	<b>DATE OF BIRTH:</b>  IF NOT KNOWN, PLEASE GIVE APPROXIMATE AGE:
<b>COMPUTER NO:</b>  	<b>TELEPHONE NO:</b>  	<b>PRESENT LOCATION OF SERVICE USER:</b>  
<b>OUTCOME</b>		
PLEASE TICK ONE OR MORE OF THE FOLLOWING:		
(1) INVESTIGATION UNDER THE SAFEGUARDING OF VULNERABLE ADULTS POLICY IS APPROPRIATE YES <input type="checkbox"/> NO <input type="checkbox"/>		
(2) REPORTED TO PSNI (AJP1 TO BE COMPLETED) YES <input type="checkbox"/> DATE _____ NO <input type="checkbox"/>		
(3) RQIA NOTIFIED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
NAME OF DESIGNATED OFFICER _____ CONTACT TELEPHONE NUMBER _____		
NAME OF INVESTIGATING OFFICER _____ CONTACT TELEPHONE NUMBER _____		
ADDRESS _____ _____ _____		
<b>Additional notes if necessary</b>  		
<b>SIGNATURE OF DESIGNATED OFFICER</b>	<b>DATE</b>	



VA4

**BELFAST HEALTH & SOCIAL CARE TRUST**

**PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS FROM ABUSE AND EXPLOITATION**

**INITIAL INFORMATION GATHERING**  
**PLANNING THE INVESTIGATION – STRATEGY INFORMATION**

**Please specify whether telephone or meeting or combination of both**  
(If discussion includes consultation with P.S.N.I under the Protocol for Joint Investigation please complete A.J.P.1)

<b>CLIENT NAME:</b>		<b>CLIENT ADDRESS:</b>	
<b>COMPUTER NO:</b>			
<b>TYPE</b>	<b>NAME OF WORKER</b>	<b>PURPOSE</b> _____	
			<b>DATE</b>
<b>TYPE</b>	<b>NAME OF WORKER</b>	<b>PURPOSE</b> _____	

		DATE
--	--	------

VA4a

**BELFAST HEALTH & SOCIAL CARE TRUST**

**PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS FROM ABUSE AND EXPLOITATION**

**OUTCOME OF STRATEGY PLANNING**

To be completed by the Designated Officer on receipt of referral

<b>NAME:</b>	<b>ADDRESS:</b>	<b>DATE OF BIRTH:</b> If not known, please give approximate age
	<b>BT</b>	
<b>COMPUTER NO:</b>	<b>TELEPHONE NO:</b>	<b>GENDER:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>
<b>IS IMMEDIATE ACTION REQUIRED TO PROTECT THE VULNERABLE ADULT?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> N/K <input type="checkbox"/> DETAIL:		
URGENT MEDICAL ATTENTION REQUIRED		Yes <input type="checkbox"/> No <input type="checkbox"/>
POLICE CONTACTED TO PRESERVE POSSIBLE FORENSIC		Yes <input type="checkbox"/> No <input type="checkbox"/>
ADDITIONAL CARE RESOURCES OR STAFF PROVIDED		Yes <input type="checkbox"/> No <input type="checkbox"/>
VULNERABLE ADULT REQUIRING PLACE OF SAFETY, OR RESPITE CARE		Yes <input type="checkbox"/> No <input type="checkbox"/>
REMOVAL OF PERSON ALLEGEDLY RESPONSIBLE		Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER (please specify)		

<b>NOTIFICATIONS/REFERRALS</b>	
DO PSNI NEED TO BE CONSULTED / INFORMED? <input type="checkbox"/> No <input type="checkbox"/> Yes	Yes <input type="checkbox"/>
DECISION DELAYED PENDING FURTHER CLARIFICATION No <input type="checkbox"/> IF YES, WHO CONTACTED THE POLICE: _____ DATE: _____	Yes <input type="checkbox"/>
NAME OF OFFICER: _____	
<b>OUTCOME:</b> SINGLE AGENCY INVESTIGATION <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
TRUST LEAD INVESTIGATION <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
JOINT AGENCY INVESTIGATION <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>DO THE RQIA NEED TO BE INFORMED?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
N/K <input type="checkbox"/> IF YES, WHO CONTACTED RQIA: _____ DATE: _____ NAME OF INSPECTOR: _____	
<b>DOES THE TRUST NEED LEGAL ADVICE?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K <input type="checkbox"/>	
IF YES, WHO SOUGHT ADVICE: _____ DATE: _____	

VA4a	
<b>OTHER CONSIDERATIONS FOR ALLOCATION OF REFERRAL</b>	
<b>(a) HAS THE SERVICE USER ANY PREFERENCES RELATING TO WHO SHOULD CARRY OUT THE INVESTIGATION? (EG GENDER)</b> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K <input type="checkbox"/> <i>IF YES, PLEASE SPECIFY:</i>	
<b>(b) HAS THE VULNERABLE ADULT ANY OTHER SPECIAL REQUIREMENTS?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K <input type="checkbox"/> <i>IF YES, PLEASE SPECIFY</i>	
<b>(c) ARE THERE ISSUES OF SAFETY FOR THE WORKER?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K <input type="checkbox"/> <i>IF YES, STATE WHAT SAFEGUARDS ARE IN PLACE:</i>	
NAME OF INVESTIGATING OFFICER:	DATE OF ALLOCATION:
<b>WILL THE VULNERABLE ADULT BE VISITED ON THE SAME DAY AS REFERRAL RECEIVED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <i>IF NO, STATE REASONS:</i>	
SIGNATURE OF DESIGNATED OFFICER:	DATE:

VA5

**BELFAST HEALTH & SOCIAL CARE TRUST**

**PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS FROM ABUSE AND EXPLOITATION**

**SIGNIFICANT INTERVIEW / EVENT REPORT**

<b>NAME OF PERSON INTERVIEWED:</b>	<b>ADDRESS:</b>	<b>WHO IS THIS PERSON? Eg. Vulnerable Adult, Carer</b>
<b>COMPUTER NO:</b>	<b>TEL. NO:</b>	
<b>NAME OF INTERVIEWER:</b>		
<b>DATE:</b>	<b>TIME:</b>	<b>VENUE:</b>
<b>PURPOSE OF THE INTERVIEW:</b>		
<b>REPORT OF INTERVIEW / EVENT:</b>		

VA5

SIGNIFICANT INTERVIEW / EVENT REPORT (CONTINUED)	
<b>SUMMARY ACTION AGREED:</b>	
SIGNATURE OF INTERVIEWER _____	DATE _____
SIGNATURE OF INTERVIEWEE _____ (IF APPROPRIATE)	DATE _____

**BELFAST HEALTH & SOCIAL SERVICES TRUST**

**PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS FROM ABUSE AND EXPLOITATION  
INVESTIGATIVE REPORT/ASSESSMENT OF RISK**

To BE COMPLETED BY THE INVESTIGATING OFFICER

<b>NAME:</b>	<b>ADDRESS:</b>	<b>DATE OF BIRTH:</b>
<b>COMPUTER NUMBER:</b>	<b>BT:</b> <b>TEL NO.</b>	
TYPE OF ABUSE (PLACE 'X' IN THE BOX OF THE ABUSE THAT TRIGGERED THE ALERT & TICK ANY OTHER ABUSE WHICH IS RELEVANT) <input type="checkbox"/> PHYSICAL <input type="checkbox"/> SEXUAL <input type="checkbox"/> PSYCHOLOGICAL/EMOTIONAL <input type="checkbox"/> FINANCIAL <input type="checkbox"/> NEGLECT <input type="checkbox"/> INSTITUTIONAL ABUSE <input type="checkbox"/> DISCRIMINATION <input type="checkbox"/> OTHER (PLEASE SPECIFY)		
<b>1. DETAILS OF REFERRAL (SPECIFY DETAILS OF INJURY / INCIDENT)</b>          NAME OF REFERRER: _____ DATE OF REFERRAL : _____ DESIGNATION: _____ TEL NO: _____		
<b>2. BACKGROUND: (TO INCLUDE FACTORS PRECIPITATING REFERRAL, HOME CIRCUMSTANCES, SUPPORT AVAILABLE, OR SUMMARY / OUTCOME OF PREVIOUS INVESTIGATIONS)</b> <b>Prompt: this section should also focus on the capabilities &amp; strengths of the client &amp; highlight the positive influences which promote their independence, personal well being, protection and quality of life</b>		
<b>3. IDENTIFY PREVIOUS OR CURRENT CONTACT WITH HEALTH &amp; SOCIAL SERVICES AND RELEVANT OTHER AGENCIES</b>		

<p><b>4. PHYSICAL HEALTH:</b></p> <p><b>SENSORY DISABILITY:</b>      VISUAL <input type="checkbox"/>    HEARING <input type="checkbox"/>    DEAF/BLIND <input type="checkbox"/></p>
<p><b>5. LEARNING DISABILITY - LEVEL OF DISABILITY:</b></p> <p><b>SERVICE USERS PERCEPTION OF DISABILITY:</b></p>
<p><b>6. MENTAL HEALTH:</b>    <i>Prompt – see Consent Issues and the Vulnerable Adult</i></p> <p><b>HAS A PSYCHIATRIC ASSESSMENT BEEN COMPLETED?</b>          DATE:    BY WHOM:          DIAGNOSIS:</p> <p><i>Other information regarding mental state/health:</i></p>
<p><b>7. CAPACITY / consent to issues under investigation:</b>          COMMENT (PLEASE INCLUDE RELEVANT REPORTS / OPINIONS AND BEAR IN MIND HOW CLIENT'S CAPACITY MIGHT BE ENHANCED):</p>
<p><b>8. STATUTORY / LEGAL ORDERS</b>          (ARE ANY OF THE FOLLOWING STATUTORY/PROTECTIVE MEASURES ALREADY IN PLACE OR WERE THEY PREVIOUSLY USED OR CONSIDERED UNDER THE MENTAL HEALTH ORDER?)</p> <p>POWER OF ATTORNEY/ENDURING POWER OF ATTORNEY <input type="checkbox"/>    REFERRED TO O.C.P <input type="checkbox"/>          NON-MOLESTATION ORDER <input type="checkbox"/>    HARRASSMENT ORDER <input type="checkbox"/>    GUARDIANSHIP <input type="checkbox"/>          ADMISSION FOR PSYCHIATRIC ASSESSMENT <input type="checkbox"/>    DETAINED FOR TREATMENT UNDER MHO <input type="checkbox"/>          OTHER <input type="checkbox"/>          COMMENTS:</p>
<p><b>9. FINANCIAL CIRCUMSTANCES (ONLY IF RELEVANT)</b></p> <p>NATIONAL INSURANCE NO: _____</p> <p>IN RECEIPT OF BENEFITS: YES <input type="checkbox"/>    NO <input type="checkbox"/>          IF YES, GIVE          DETAILS: _____</p> <p>OTHER INCOME:                                      YES <input type="checkbox"/>    NO <input type="checkbox"/>          IF YES, GIVE          DETAILS: _____</p> <p>AGENT/APPOINTEE CONTROLLER IN PLACE?    YES <input type="checkbox"/>    NO <input type="checkbox"/>          IF YES, GIVE          DETAILS: _____</p>
<p><b>10. CARER'S ASSESSMENT:</b> OFFERED <input type="checkbox"/>    ACCEPTED <input type="checkbox"/>    DECLINED <input type="checkbox"/>    NOT APPLICABLE <input type="checkbox"/></p>

11.

**RISK ANALYSIS (VA6)**

<b>ABUSE / RISK IDENTIFIED</b>			
<b>IDENTIFIED BY WHOM</b>			
<b>SPECIFIC EVIDENCE OF RISK / ABUSE</b>			
<i>Pattern of abuse</i>	Isolated <input type="checkbox"/> Occasional occurrence <input type="checkbox"/> Repeated occurrence <input type="checkbox"/> Established pattern <input type="checkbox"/>	Isolated <input type="checkbox"/> Occasional occurrence <input type="checkbox"/> Repeated occurrence <input type="checkbox"/> Established pattern <input type="checkbox"/>	Isolated <input type="checkbox"/> Occasional occurrence <input type="checkbox"/> Repeated occurrence <input type="checkbox"/> Established pattern <input type="checkbox"/>
<b>PROBABILITY REOCCURRING</b>	Unlikely <input type="checkbox"/> Likely <input type="checkbox"/> High Probable <input type="checkbox"/> Certainty <input type="checkbox"/>	Unlikely <input type="checkbox"/> Likely <input type="checkbox"/> High Probable <input type="checkbox"/> Certainty <input type="checkbox"/>	Unlikely <input type="checkbox"/> Likely <input type="checkbox"/> High Probable <input type="checkbox"/> Certainty <input type="checkbox"/>
<b>SEVERITY OF ABUSE/ RISK</b>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Serious <input type="checkbox"/> Death <input type="checkbox"/>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Serious <input type="checkbox"/> Death <input type="checkbox"/>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Serious <input type="checkbox"/> Death <input type="checkbox"/>
<b>SITUATIONAL FACTORS</b>			
<b>POSITIVE FACTORS WHICH MINIMISE RISK</b>			
<b>SERVICE USER / CARERS PREFERRED CHOICE / EXPRESSED WISHES</b>			
<b>ADDITIONAL</b>			



<b>COMMENT</b>			
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VA6

**12. INVESTIGATION OUTCOME**

FURTHER INVESTIGATION REQUIRED  CONFIRMED ABUSE   
 ALLEGATIONS ARE UNCONFIRMED  NO ABUSE   
 OTHER  SPECIFY \_\_\_\_\_

Where allegations are confirmed place x in the box to note the main form of abuse.  
 If there are other types of abuse please tick relevant box.

PHYSICAL  SEXUAL  PSYCHOLOGICAL/EMOTIONAL   
 FINANCIAL  NEGLECT  INSTITUTIONAL ABUSE  DISCRIMINATION   
 OTHER  SPECIFY \_\_\_\_\_

**(b) HAS CASE DISCUSSION/CONFERENCE BEEN CONVENED -**

YES  DATE \_\_\_\_\_  
 NO  PROCEED TO 16C

CLIENT INVITED - YES  NO

If no give reason: \_\_\_\_\_

CARER INVITED - YES  NO

If no give reason: \_\_\_\_\_

Advocate invited - YES  NO

IF NO GIVE REASON: \_\_\_\_\_

**(c) IF A CASE CONFERENCE IS NOT CONVENED PLEASE STATE REASON**

**13. RISK TO OR FROM OTHERS**

• ARE THERE RISKS TO CHILDREN AND YOUNG PEOPLE YES  NO   
 • HAS THIS BEEN REFERRED TO THE APPROPRIATE AGENCY YES  NO   
 IF YES, PLEASE NOTE WHO THE REFERRAL WAS MADE TO:

• ARE THERE RISKS TO OTHER VULNERABLE ADULTS YES  NO   
 IF YES, NOTE THE DISCUSSION AND ACTION AGREED BY DESIGNATED OFFICER:

• WHERE APPROPRIATE HAVE SUPPORT / SERVICES BEEN OFFERED TO THE PERSON ALLEGEDLY RESPONSIBLE FOR THE ABUSE? YES  NO   
 IF YES, PLEASE SPECIFY:

SERVICE USER'S SIGNATURE \_\_\_\_\_  
 DATE \_\_\_\_\_

SIGNATURE OF INVESTIGATING OFFICER \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF DESIGNATED OFFICER \_\_\_\_\_ DATE \_\_\_\_\_



**BELFAST HEALTH & SOCIAL SERVICES TRUST  
PROTECTION PLAN**

VA6A

14.

<i>NAME:</i>	<i>DATE CREATED:</i>	<i>DATE OF COMMENCEMENT:</i>	<i>DATE OF REVIEW:</i>
--------------	----------------------	------------------------------	------------------------

<i>Risk</i>	<i>Assessed need</i>	<i>intervention</i>	<b>BY WHOM</b>	<b>REASON FOR NOT TAKING ANY ACTION</b>
1.				
2.				
3.				
4.				
5.				

**UNMET NEEDS:** (IF THERE ARE UNMET NEEDS, IDENTIFY WHEN THIS NEED CAN BE MET AND / OR THE ALTERNATIVE SERVICES THAT HAVE BEEN PROVIDED)

**15. ARE ANY OF THE FOLLOWING STATUTORY / PROTECTIVE MEASURES REQUIRED / INDICATED? PLEASE TICK**

(i) OFFICE OF CARE AND PROTECTION <input type="checkbox"/>	(ii) GUARDIANSHIP <input type="checkbox"/>	(iii) ADMISSION FOR ASSESSMENT <input type="checkbox"/>
(iv) ADMISSION TO CARE <input type="checkbox"/>	(v) NON-MOLESTATION ORDER <input type="checkbox"/>	(vi) DETAINED FOR TREATMENT <input type="checkbox"/>
<input type="checkbox"/>		



**16. THE USERS / CARERS COMMENTS**

*(THE USER / CARER CAN COMPLETE THIS SECTION. THIS IS AN OPPORTUNITY FOR THE USER / CARER TO SAY WHAT THEY THINK OF THE PROTECTION PLAN AND HOW THEY HAVE BEEN INVOLVED IN DRAWING IT UP. THE USER / CARER WILL WRITE IN THEIR OWN COMMENTS OR THEY MIGHT WANT SOMEONE ELSE TO FILL IN THEIR VIEWS)*

USER'S SIGNATURE:	<b>AND/OR CARER / ADVOCATE / REPRESENTATIVES SIGNATURE:</b>
DATE:	DATE:

INVESTIGATING OFFICER SIGNATURE:	DESIGNATED OFFICER SIGNATURE:
DATE:	DATE:



**BELFAST HEALTH & SOCIAL CARE TRUST  
PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS  
FROM ABUSE AND EXPLOITATION**

**MINUTES OF STRATEGY MEETING /  
CASE DISCUSSION / REVIEW**

This provides a template to record who attended the meeting, reports submitted and future review arrangements. The Designated Officer will also include a minute of the essential facts, discussion and decisions taken at the meeting.

<b>NAME:</b>	<b>ADDRESS:</b>	<b>DATE OF BIRTH:</b>
<b>COMPUTER NO:</b>		IF NOT KNOWN, PLEASE GIVE APPROXIMATE AGE:
		GENDER: M <input type="checkbox"/> F <input type="checkbox"/>
<b>VENUE:</b>	<b>DATE</b>	
<b>CHAIR PERSON:</b>		
<b>WAS THE USER INVITED?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>WAS THE USER IN ATTENDANCE?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>DID THE USER COMMUNICATE THEIR VIEWS BY OTHER MEANS EG. LETTER</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>IF THE USER DID NOT PARTICIPATE, PLEASE SPECIFY REASON</b> _____		
<b><u>OTHERS INVITED IE. ADVOCATE OR CARER</u></b>		
NAME _____	IN ATTENDANCE	YES <input type="checkbox"/> NO <input type="checkbox"/>
NAME _____	IN ATTENDANCE	YES <input type="checkbox"/> NO <input type="checkbox"/>
IF NOT INVITED OR DID NOT ATTEND SPECIFY REASON _____		
<b>NAMES OF THOSE PRESENT:</b>	<b>TITLE</b>	
<b>LIST OF APOLOGIES RECEIVED</b>		
1. _____	6. _____	
2. _____	7. _____	
_____		
<b>REPORTS SUBMITTED BY:</b>		
1. _____	3. _____	
2. _____	4. _____	
_____		
<b>INVESTIGATIVE OUTCOME / ARE THERE REASONABLE GROUNDS FOR ONGOING CONCERN:</b>		





VA8

**BELFAST HEALTH AND SOCIAL CARE TRUST**

**PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS FROM ABUSE AND EXPLOITATION**

**REVIEW OF CARE/PROTECTION PLAN**

To be completed by the Designated Officer

NAME:	COMPUTER NO:	
	DATE OF LAST REVIEW:	DATE OF THIS REVIEW
<b><u>WHO HAS BEEN CONTACTED?</u></b>		
<b><u>Vulnerable Adult</u></b>	<input type="checkbox"/> RQIA	<input type="checkbox"/> Psycho Geriatrician <input type="checkbox"/>
<b><u>Domiciliary Provider</u></b> <input type="checkbox"/>		
Carer	<input type="checkbox"/> Doctor/Consultant	<input type="checkbox"/> District Nurse <input type="checkbox"/>
Care Manager	<input type="checkbox"/>	
Relative	<input type="checkbox"/> Psychologist	<input type="checkbox"/>
Hospital Nurse <input type="checkbox"/>	Res. or Day Care	<input type="checkbox"/>
Police <input type="checkbox"/>	<input type="checkbox"/> Psychiatrist <input type="checkbox"/> Community Psy. Nurse <input type="checkbox"/>	Rehab-Worker <input type="checkbox"/>
Social Work Asst. <input type="checkbox"/>	<input type="checkbox"/> Other, please specify <input type="checkbox"/> _____	
REVIEW AND AMEND PREVIOUS ANALYSIS OF RISK. COMMENTS:		
REVIEW AND AMEND PROTECTION PLANS. COMMENTS:		
ARE THERE ANY UNRESOLVED ISSUES? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, SPECIFY HOW THESE MAY BE ADDRESSED.		

INVESTIGATION OUTCOME				
CONFIRMED ABUSE <input type="checkbox"/>	ALLEGATIONS ARE UNSUBSTANTIATED <input type="checkbox"/>	NO ABUSE <input type="checkbox"/>		
Where allegations are confirmed place x in the box to note the main form of abuse. If there are other types of abuse please tick relevant box.				
PHYSICAL <input type="checkbox"/>	FINANCIAL <input type="checkbox"/>	EMOTIONAL <input type="checkbox"/>	SEXUAL <input type="checkbox"/>	NEGLECT <input type="checkbox"/>
INSTITUTIONAL ABUSE <input type="checkbox"/>				
<b>WILL THIS CASE BE REVIEWED UNDER THE VULNERABLE ADULTS POLICY AND PROCEDURES?</b>				
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	

VA8

**IF YES,**

WILL THE REVIEW BE VIA:

SUPERVISION      DATE: \_\_\_\_\_

CASE CONFERENCE      DATE: \_\_\_\_\_

WILL THE DESIGNATED AND INVESTIGATING OFFICER REMAIN THE SAME

YES     NO

IF NO, PLEASE SPECIFY, DESIGNATED OFFICER

\_\_\_\_\_

INVESTIGATING OFFICER

\_\_\_\_\_

**IF NO,**

INVESTIGATING OFFICER WILL CONTINUE WITH A KEY WORKER ROLE

TRANSFER TO OTHER KEY WORKER / SERVICE, PLEASE SPECIFY  
\_\_\_\_\_

CLOSE CASE

OTHER, PLEASE SPECIFY \_\_\_\_\_

**SIGNATURE OF DESIGNATED OFFICER**

**DATE**



**BELFAST HEALTH AND SOCIAL CARE TRUST**

**PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS FROM ABUSE AND EXPLOITATION**

**CLOSURE / TRANSFER SUMMARY**

<b>NAME:</b>  <b>ADDRESS:</b>
<u>Reason for transfer / closure - specify</u>  
<b>OTHER ACTIONS</b> <input type="checkbox"/> INVESTIGATING OFFICER WILL CONTINUE WITH A KEY WORKER ROLE <input type="checkbox"/> TRANSFER TO OTHER SERVICES, <i>SPECIFY:</i> <input type="checkbox"/> TRANSFER TO ANOTHER TRUST INVESTIGATING OFFICER - NAME  <input type="checkbox"/> TRANSFER TO OTHER TRUST / BOARD. NAME OF WORKER _____ <div style="text-align: center;">AGENCY</div> <input type="checkbox"/> OTHER, PLEASE SPECIFY _____
<u>user involvement</u>  USER INFORMED OF TRANSFER / CLOSURE? YES <input type="checkbox"/> NO <input type="checkbox"/> DATE _____ USER AGREEABLE TO TRANSFER / CLOSURE? YES <input type="checkbox"/> NO <input type="checkbox"/> IF NO, OUTLINE REASONS FOR DISAGREEMENT   USER NOTIFIED OF TRANSFER / CLOSURE BY LETTER YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPROPRIATE <input type="checkbox"/>
<u>Involvement of significant others and the multi-disciplinary team</u>  <b>HAS ANYONE EXPRESSED A CONTRARY VIEW TO THE TRANSFER / CLOSURE?</b> YES <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> IF YES, PLEASE STATE WHY, THE GROUNDS FOR THEIR RESERVATION AND HOW THIS WAS RESOLVED  _____ _____ _____
<b>WHO HAS BEEN NOTIFIED BY LETTER OF THE TRANSFER / CLOSURE;</b>  <input type="checkbox"/> CARER / ADVOCATE, SPECIFY WHO _____ <input type="checkbox"/> GENERAL PRACTITIONER <input type="checkbox"/> PSYCHIATRIST / PSYCHOGERIATRICIAN <input type="checkbox"/> CONSULTANT <input type="checkbox"/> DISTRICT NURSE <input type="checkbox"/> COMMUNITY PSYCHIATRIC NURSE <input type="checkbox"/> SOCIAL WORK ASSIT

<input type="checkbox"/> COMMUNITY NURSE FOR PEOPLE WITH LEARNING DISABILITY <input type="checkbox"/> POLICE <input type="checkbox"/> REGISTRATION & INSPECTION <input type="checkbox"/> LEGAL REPRESENTATIVE <input type="checkbox"/> PSYSIOTHERAPIST <input type="checkbox"/> OCCUP. THERAPIST <input type="checkbox"/> CARE MANAGER <input type="checkbox"/> REHAB. WORKER <input type="checkbox"/> WARD MANAGER <input type="checkbox"/> OTHER <i>SPECIFY</i> :	
<b>SIGNED INVESTIGATING OFFICER</b>	<b>DATE</b>
<b>SIGNED DESIGNATED OFFICER</b>	<b>DATE</b>

**Belfast Health & Social Care Trust****LIST OF TRUST DESIGNATED OFFICERS (May2010)**

<b>Social Worker Trained</b>	<b>Programme of Care</b>	<b>Work Place</b>	<b>Contact Number</b>
Carmel Fairmichael	Older People	Shankill Centre, 151-157 Shankill Road,	90315005
John Allen	Older People	Carlisle Centre, 40 Antrim Road	90163757
Fiona Mc Kinney	Older People	Twin Spires	90636261
Ann Kernaghan	Older people	Knockbracken Health Care Park	90565707
Mairead Campbell	Older people	KHCP	90565707
Nuala Kelly	Older people	Provider Unit Carlisle Centre 40 Antrim Road	90163707
Yvonne Mc Knight	Older People	KHCP	90565707
Deirdre Hegarty	Older People	KHCP	90565707
David Shaw	Older People	Arches Centre	90563330
Geralyn Ainsworth	Older People	Shankill Centre	90315005
Pat Fitzpatrick	Older People	Bradbury Centre	90912090
Dermot Dawson	Older People	Twin Spires	90417400
May Newberry	Older People	Gilnahirk	90797383
Sandra Cullen	Physical Health and Disability	Mount Oriel	90704138
Michelle Shannon	Physical Health & Disability	Grove Health & Well being Centre	90 636814
Jane McMillen	Physical Health & Disability/ Sensory support	Everton Complex	90 566001
Joe Mulholland	Physical Health & Disability/ Sensory support	Everton Complex	90636821
Tracey Reid	Physical Health & Disability	Grove Health & Well being Centre	90636821
Joan Mc Crudden	Sensory Support	Bradbury Centre	90912190
Colette Ireland	Learning Disability	Finaghy Library	90204820
Mildred Lorimer	Learning Disability	Maureen Sheehan Centre	90242816

Document1

## Appendix 4

<b>Social Worker Trained</b>	<b>Programme of Care</b>	<b>Work Place</b>	<b>Contact Number</b>
Carmel Drysdale	Learning Disability	Carlisle Centre 2 <sup>nd</sup> Floor 40,Antrim Road	90163595
Davy Mc Dowell	Learning Disability	Finaghy Library	90204820
Neil Kelly	Learning Disability	Everton complex	90566038
Aine Morrison	Learning Disability	Fairview	90802366
Barry Mills	Learning Disability	Muckamore Abbey Hospital	94 4834070
Clinton Stewart	Learning Disability	Muckamore Abbey Hospital	94 4834070
Rhoda Mc Bride	Mental health	Woodstock	90737548
Michael Bell	Mental health	Windsor Unit, BCH	90263646 90263929 07810182841
Jackie Mc Ilroy	Mental Health	Knockbracken Clinic	90565922
Mary O'Brien	Mental Health	Everton complex	90566040
Jackie Scott	Mental Health	Shannon, Knockbracken Health Care Park	90916837
Pat Knowles	Hospital	RVH	90632450
Mandy Cowden	Hospital	RVH	90632450
Mary Fagan	Hospital	RVH	90632450
Louise Derrick	Hospital	BCH	90263600
Lorraine Mc Farland	Hospital	Meadowlands- Intermediate and SW service groups- Musgrave Park Hospital	90902458
Christina Doyle	Hospital	BCH	90263600
Fred Davidson	Hospital	Mater Hospital	90802435
Mary Diamond	Care Management	Everton Complex	90566000

Document1



**Key Contacts / External Agencies**

**Contact details for the Regulation and Quality Improvement Authority between 9.00am – 5.00pm Monday to Friday**

The RQIA Headquarters is located in Belfast at:

The Regulation and Quality Improvement Authority  
9<sup>th</sup> Floor Riverside Tower  
5 Lanyon Place  
Belfast  
BT1 3BT  
Phone: (028) 90517500

RQIA is an independent professional body with responsibility for quality assurance in relation to regulated services. They have an inspection function and are required to ensure that legislative requirements in relation to regulation and standards are met.

In relation to vulnerable adult abuse allegations, regulated services are required to follow RQIA reporting procedures.

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**Police Service of Northern Ireland: (028) 90650222**

**Contact details for referrals to Public Protection Units between 9.00am – 5.00pm Monday to Friday**

**A District – North & West Belfast**

Inspector Ext 28950 Sergeant Ext 28826

**B District – South & East Belfast**

Inspector Ext 23594 Sergeant Ext 23579

**C District – North & South Down, Ards and Castlereagh**

Inspector Ext 31160 Sergeant Ext 15782

Allegations of abuse which constitute a crime must be reported to PSNI and consideration given to whether the 'Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' (July 2009) is applicable.

In all referrals regarding Vulnerable Adults, the Sergeant attached to the relevant PPU will be the first point of contact.

Outside of usual office hours (9.00am – 5.00pm, Monday to Friday) the Duty Inspector in the relevant District should be contacted.

**Independent Safeguarding Authority:**

Document1

Po Box 181  
Darlington  
County Durham  
DL1 9FA

Phone: 0300 123 1111

The Independent Safeguarding Authority (ISA) is a non-departmental public body with responsibility for implementation of the new Vetting and Barring Scheme in England, Wales and Northern Ireland. ISA will require all those working with vulnerable groups to undergo an enhanced vetting procedure before being allowed to commence any relevant duties.

Staff in regulated services will be required to register with ISA over a phased period of time, with implementation of new staff effective immediately. In addition, when concerns emerge regarding poor practice or abuse, consideration needs to be given to referral on to ISA regarding possible barring requirements.

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Document1



TYPE OF DOCUMENT

Trust Policy for approval by **Trust Policy Committee**

<b>REFERENCE NUMBER</b>	TP052/10
<b>TITLE</b>	PROTOCOL FOR THE RECRUITMENT AND EMPLOYMENT OF STAFF UNDER THE REQUIREMENTS OF THE SAFEGUARDING VULNERABLE GROUPS (NI) ORDER (SVGO) 2007 AND VETTING AND BARRING SCHEME INTERIM GUIDANCE (PENDING FURTHER REVIEW)
<b>Summary</b>	This Protocol outlines the key responsibilities of the Belfast Health and Social Care Trust (the Trust) in relation to the implementation arrangements of the SVGO Vetting and Barring Scheme as it relates to the employment of staff, the recruitment of prospective staff and the placement of students, volunteers, trainees and other non employees.
<b>Supersedes</b>	<i>BHSCT POCVA Policy</i>
<b>Operational date</b>	<i>July 2010</i>
<b>Review date</b>	<i>July 2011</i>
<b>Version Number</b>	<i>V1</i>
<b>Director Responsible</b>	<i>Marie Mallon</i>
<b>Lead Author</b>	Louise Beckett
<b>Lead Author, Position</b>	Senior HR Manager
<b>Department / Service Group</b>	Human Resources
<b>Contact details</b>	<i>Louise Beckett</i> [REDACTED]
<b>Additional Author(s)</b>	

Trust Policy – Recruitment and employment of staff under the requirements of the safeguarding vulnerable groups.  
August 2010

BHSCT - E - 00033 – Protocol for Recruitment and Employment of staff under requirements of Safeguarding Vulnerable Groups\_2010.07\_V1 (49 pages) – (00136)

1 of 49

BT Mod 3 Witness Stmt 20 Mar 2023 PART 4 OF 9 Exhibit Bundle (3 of 8) (T05-T06)  
(pp5404-8369 of 20966) (this part 2966 pages)

6505 of 8369

**Version Record**

Date	Version	Author	Comments
23.03.10	0.1	L Beckett	Initial Draft
09.06.10	0.2	L Beckett	Final Draft
	1		Approved – for dissemination

**Policy Record**

		Date	Version
Author (s): Louise Beckett	Approval	09/06/10	0.2
Director Responsible: Marie Mallon	Approval	09/06/10	

**Approval Process – Trust Policies**

Policy Committee	Approval	21.06.10	
Executive Team	Authorise	23.06.10	
Chief Executive	Sign Off	23.06..10	

**Approval Process – Clinical Standards and Guidelines**

Standards and Guidelines Committee	Approval		
Policy Committee	Ratify		
Executive Team	Authorise		
Appropriate Director	Sign Off		

**Local Approval Process**

	Approval		
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**Dissemination**

Areas :	

**Title:**

Protocol for the Recruitment and Employment of Staff under the Requirements of the Safeguarding Vulnerable Groups (NI) Order (SVGO) 2007 and the Vetting and Barring Scheme

**Purpose:**

To provide guidance on the SVG Vetting and Barring Scheme

**Objectives:**

1. To outline the key provisions of the SVG Vetting and Barring Scheme
2. To detail the responsibilities of the Trust and its staff
3. To provide guidance, clarification and direction to further sources of information in the implementation of SVG Vetting and Barring Scheme

**Policy Statement(s):**

- 1 The protocol outlines the legislative context and responsibilities under the SVG Vetting and Barring Scheme
- 2 It sets out the main provisions of the VBS as it relates to conducting checks for new and current employees and the referral arrangements for existing employees
- 3 It provides advice and clarification on the key elements of the VBS and a number of sources for further information and documentation.



*Louise Beckett*

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**Director of Human Resources**

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**Author**

*Printed Name Louise Beckett*

**Date: 23 June 2010**

**Date: 14/6/10**




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**Chief Executive**

**Date: 23 June 2010**

## **Full Description**

### **Contents Page**

#### **Title:**

Protocol for the Recruitment and Employment of Staff under the requirements of the Safeguarding Vulnerable Groups (NI) Order (SVGO) 2007 and the Vetting and Barring Scheme

#### **Purpose:**

To provide guidance on the SVG Vetting and Barring Scheme.

#### **The Scope:**

The Protocol covers the responsibilities of the Trust, Line Managers and Human Resources Staff and applies to existing staff, potential employees, volunteers and disability placements on work experience.

#### **Objectives:**

1. To outline the key provisions of the SVG Vetting and Barring Scheme
2. To detail the responsibilities of the Trust and its staff
3. To provide guidance, clarification and direction to further sources of information in the implementation of SVG Vetting and Barring Scheme

#### **Roles and Responsibilities:**

The specific responsibilities of the Trust, its managers and Human Resources staff are outlined.

#### **The definition and background of the policy:**

The Protocol was developed as a request of the SVG (NI) Order 2007 which established the Vetting and Barring Scheme and replaces the former Protection of Children and Vulnerable Adults (NI) Order 2003.

#### **Policy / Guideline description:**

The Protocol outlines the key provisions and associated responsibilities of the SVG Vetting and Barring Scheme.

#### **Policy statements:**

1. The protocol outlines the legislative context and responsibilities under the SVG Vetting and Barring Scheme.
2. It sets out the main provisions of the VBS as it relates to conducting checks for new and current employees and the referral arrangements for existing employees.
3. It provides advice and clarification on the key elements of the VBS and a number of services for further information and documentation.

**Implementation/Resource requirements:**

Additional resources will be required by Human Resources and Finance staff in relation to the phasing arrangements for existing staff which will commence in April 2011 for a 4 year period.

**Source(s) / Evidence Base:**

The Protocol adheres to legislative requirements of the SVG Vetting and Barring Scheme.

**References, including relevant external guidelines:**

DHSSPS Generic Guidance, Sector Specific Guidance, ISA Referral Guidance and Access NI Guidance.

**Consultation Process:**

The Protocol was fully consulted on with the Trusts SVG Stakeholders' Groups at which Service Groups, Trade Unions and Human Resources are represented.

**Equality and Human Rights screening carried out:**

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.

✓ Screening completed  
No action required.

Full impact assessment to be carried out.

**n. Procedures:**

Procedures assist with new and existing staff and referral arrangements are set out in the Protocol.



*Louise Beckett*

\_\_\_\_\_  
**Director of Human Resources**

\_\_\_\_\_  
**Author**

**Date: 23 June 2010**

**Date: 14/6/10**



\_\_\_\_\_  
**Chief Executive**

**Date: 23 June 2010**



Belfast Health and  
Social Care Trust

## **PROTOCOL FOR:**

# **RECRUITMENT AND EMPLOYMENT OF STAFF UNDER THE REQUIREMENTS OF THE SAFEGUARDING VULNERABLE GROUPS (NI) ORDER (SVGO) 2007 AND THE VETTING AND BARRING SCHEME**

## **INTERIM GUIDANCE PENDING FURTHER REVIEW**

**JUNE 2010**



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## **Protocol for the Recruitment and Employment of Staff under the requirements of the Safeguarding Vulnerable Groups (NI) Order (SVGO) 2007 Vetting and Barring Scheme**

### **1 PURPOSE AND SCOPE OF PROTOCOL**

This Protocol outlines the key responsibilities of the Belfast Health and Social Care Trust (the Trust) in relation to the implementation arrangements for the SVGO Vetting and Barring Scheme as it relates to the employment of staff, the recruitment of prospective staff and the placement of students, volunteers, trainees and other non employees. The Trust has been entrusted with the care of children and vulnerable adults and must be confident that all the necessary safeguards and controls are in place to ensure that children and vulnerable adults are protected. The Trust has a range of responsibilities emanating from its statutory remit in respect of Fostering, Adoption and Early Years' Services. The practice across the Trust in these service sectors is informed by various Regulations, Policies and Procedures which can be accessed via the Social Work Social Care Governance service area.

This Protocol has been developed as part of the Trust's Safer Recruitment and Employment Framework in relation to the specific requirements for the Belfast Trust and **must** be read in conjunction with the more detailed Generic and Sector Specific Guidance on the Vetting and Barring Scheme which can be accessed at [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk) and the Referral Guidance which can be accessed at [www.isa.gov.org.uk](http://www.isa.gov.org.uk) The Protocol summarises the key details of the new legislation and the Vetting and Barring Scheme and outlines the procedural arrangements which have been put in place to implement these. It is not intended to be a definitive guide to the Legislation or Scheme. It should be noted that Sir Roger Singleton's review will result in the need to review this protocol and further developments may also necessitate amendment. Consequently this protocol should be considered as interim guidance or work in progress.

### **2 LEGISLATIVE CONTEXT**

The Bichard Inquiry into the murders in Soham resulted in a recommendation for a new scheme that would ensure that everyone working in regulated activity with children and vulnerable adults is checked and registered. After full consultation the Bichard Inquiry led to the Safeguarding Vulnerable Groups Act (SVGA) 2006 and the Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 which provide for the establishment of the Vetting and Barring

Scheme. This Legislation and Scheme replace the former Protection of Children and Vulnerable Adults (NI) Order 2003 (POCVA).

The Vetting and Barring Scheme became effective on 12 October 2009. It recognises the need for a single process to assess all individuals who wish to do certain work or volunteer with children and vulnerable adults. The Independent Safeguarding Authority (ISA) has been established as part of this process across England, Wales and Northern Ireland. It has four statutory duties – to maintain a list of individuals barred from engaging in regulated activity with children; to maintain a list of individuals barred from engaging in regulated activity with vulnerable adults; to make well informed and considered decisions about whether an individual should be included in one or both barred lists; and to reach decisions as to whether to remove an individual from a barred list.

In addition, while the Vetting and Barring Scheme will provide significant safeguards, it is part of a wider framework of safe recruitment practices. In particular Access Northern Ireland (ANI), which became effective in April 2008 and operates under the provisions of Part V of the Police Act 1997, was established by a joint programme between the NI Office, the DHSSPS, the Department of Education and the PSNI. It enables organisations to make more informed recruitment decisions by providing criminal history information about anyone seeking paid or unpaid work in areas working with children and vulnerable adults. ANI offers two levels of disclosure Standard and Enhanced – each of which represents a different level of check.

A Standard Disclosure Certificate shows details of spent and unspent convictions and cautions – not cases pending.

An Enhanced Disclosure Certificate contains all the information in a Standard Disclosure and any further relevant information held in Police records eg information about attempted prosecutions that were unsuccessful or behaviour that might be indicative of criminal activity.

Standard Disclosure Certificates are no longer available for people working with children or vulnerable adults and an Enhanced Disclosure Certificate will be obtained in these circumstances.

Detailed information about ANI is available by accessing its website: [www.accessni.gov.uk](http://www.accessni.gov.uk)

In applying this Policy reference must be made to the Access NI Code of Practice, The Explanatory Guide and the Guide to Access NI.

### **3 MAIN PROVISIONS OF THE VETTING AND BARRING SCHEME**

- The Vetting and Barring Scheme (VBS) was launched on 12 October 2009 when the definitions of regulated and controlled activity came into operation – general definitions of these activities are set out in Appendix 1 – the Guidance should be referred to in relation to the full definitions. It should be noted that Controlled Activity may be reviewed as a result of a review undertaken by Sir Roger Singleton and this protocol will be amended to reflect this as appropriate. From 12 October 2009 it is an offence for a barred individual to work in regulated activity or for the Trust to knowingly allow someone to work in regulated activity while barred.
- From 12 October 2009 the barred lists – List 99, the Protection of Children’s Act List (POCA), the Protection of Vulnerable Adults List in England and Wales(POVA) and the Disqualification from Working with Vulnerable Adults List in NI, as well as the current system of disqualification orders that is operated by the criminal justice system were phased out and have been replaced by two new lists: the Children’s Barred List and the Adults’ Barred List. These lists will contain details of those individuals the ISA has decided it is appropriate to bar from working with children or vulnerable adults and who are therefore prevented from working or volunteering with them. The ISA will maintain these lists.
- The Trust will be eligible to ask for enhanced disclosures with barred list checks for any potential employee to regulated activity. The Trust will also be eligible to request this for those who may work in controlled activity posts. The DHSSPS will be undertaking a consultation exercise in relation to the need for Statutory EDCs for groups of staff who fall within existing regulations associated with Nursing/Residential/Children’s Homes etc. The outcome of this consultation exercise will further inform this Protocol.
- From 12 October 2009, if the Trust removes an employee, or someone for whom it is responsible, from regulated or controlled activity, or if an employee leaves while under investigation or allegedly causing harm or posing a risk of harm, the Trust is legally required to refer this person to the ISA. Failure to do so is an offence that carries a significant penalty.
- From 26 July 2010 individuals may apply for ISA registration if they move into a new role, paid or voluntary, which meets the definition of regulated activity
- From 1 November 2010 new workers or those moving into regulated activity, paid or voluntary, must apply for ISA registration before starting in that role It will be a criminal offence to work in a regulated activity role without being ISA registered. The Trust will have a legal duty to check that potential new employees/volunteers are ISA registered before allowing them to engage in regulated activity

- From 1 April 2011 employees already working in regulated activity may apply for ISA registration. This will be implemented on a phased approach in partnership with ANI
- From 1 January 2014 the Government will recommend that people working in controlled activity should apply for ISA registration
- The final cut off date by which everyone working in both regulated and controlled activity must be ISA registered (except any barred people in controlled activity who cannot register) is 31 July 2015

#### **4 RESPONSIBILITIES OF BELFAST HEALTH AND SOCIAL CARE TRUST**

The Belfast Health and Social Care Trust is a Regulated Activity Provider (RAP) and is responsible for the management or control of regulated activity, paid or unpaid, and makes arrangements for people to work in that activity. The Trust is required to fully implement all the requirements of the SVGO legislation and VBS as set out in the DHSSPS/ISA/ANI Guidance and Legislation.

The Trust is a Registered Body with Access NI and can access the services of ANI to obtain checks on prospective and current employees. As a Registered Body the Trust has a critical role in the management of any information disclosed.

The Trust's Recruitment and Selection Policy has been reviewed to ensure compliance with the requirements of VBS as it relates to prospective employees to ensure that checks are carried out to ensure that members of staff are who they say they are, have the skills and qualifications they say they have, are registered with the appropriate regulatory body as necessary, have undergone appropriate pre employment health screening, that references are checked and that gaps in employment are questioned. The Trust will ensure that following recruitment staff will be effectively managed, supervised, trained and appraised to ensure that they are carrying out their responsibilities in a diligent and compassionate way. In relation to students, placements and volunteers the Trust will ensure that the requirements of VBS are undertaken in line with this Protocol.

The Trust's Disciplinary Policy has been reviewed and supplemented by guidance to ensure that the necessary referral requirements set out under the VBS are adhered to.

## 4.1 SPECIFIC RESPONSIBILITIES

### The Trust: -

- must be a Registered Body with ANI and adhere to its Code of Practice and Explanatory Guide so that checks can be made against: Criminal Record Viewer, The Police National Computer and where appropriate information from Police Forces throughout the UK for any additional non-conviction material, including cases pending, which the Police consider relevant for Disclosure. The Trust has a written Statement of Intent which sets out its responsibilities for the correct handling and safekeeping of Disclosure information – attached as appendix 2
- must ensure that the appropriate arrangements are in place to ensure posts are identified as being regulated or controlled activity and that the appropriate checks are made
- must ensure that individuals are registered with the ISA before being engaged in regulated activity with effect from 1 November 2010 and that a system is in place to manage the implications, including financial, associated with this
- must not knowingly employ in a regulated activity or use as a volunteer a barred person
- must refer, with effect from 12 October 2009, to the ISA any employee or volunteer in regulated or controlled activity who has been dismissed or no longer used because the Trust thinks they have harmed or pose a risk of harm to children or vulnerable adults
- must ensure that an implementation plan is in place to ensure that the phased registering of the whole workforce is achieved effectively by 31 July 2015

### Line Managers:-

- must ensure that they and their staff are familiar with this Protocol and the Guidance referred to and keep abreast of further developments
- must identify on the Trust's online advertisement request form – refer to appendix 3 – if a vacant post meets the definition of regulated or controlled activity and requires an appointee to be registered and vetted
- must identify any staff who transfer on a permanent or temporary basis from a position that does not fall within the definition for regulated or controlled activity as appropriate to a post that does meet the definitions and ensure that these staff are registered and vetted appropriately prior to commencement in the new position

- Must ensure that the ISA registration of any staff returning from an employment break/unpaid leave is checked
- must liaise with Human Resources staff in relation to any students/training positions/other individuals to ensure that vetting is conducted as appropriate
- must alert Senior Management and Human Resources staff to any incident which gives rise to concern or where allegations are made about an individual working with children/vulnerable adults. Advice and guidance on issues which may give rise to the referral of information to ISA will be provided by the Employment Law Team

### **Human Resources Staff:-**

- must ensure that they are fully conversant with and adhere to the requirements of this Protocol and associated guidance in the recruitment and placement of staff
- must ensure that they are conversant with and adhere to the requirements of this Protocol and associated guidance in relation to the referral of any staff to the ISA
- must provide guidance and support to Line Managers in the implementation of this Protocol
- must ensure that associated Policies – Disciplinary, Recruitment and Selection, Work Experience, Honorary Appointments, Employment Breaks—are kept under review to ensure compliance with this Procedure
- must ensure that there is adherence to the Statement of Intent for the management, handling and storage of completed application forms and disclosure certificates and that the Governance Arrangements set out in Section 6 of this protocol are satisfied
- must review the Protocol on an annual basis, and at earlier intervals where appropriate, to ensure it is reflective of any legislative or procedural changes

## **5 CONDUCTING CHECKS UNDER VBS**

From November 2010 the Trust will be legally required to check that prospective employees or existing staff who move into a regulated activity position, temporary or permanent, are registered with the ISA. This will also include volunteers, student/training positions and those on honorary contracts. The Trust's Recruitment Team will ensure that this requirement is incorporated into its pre employment checking requirements. Appendix 4 to this procedure sets out the positions for which ISA registration is required. This list is not definitive and is subject to review.

## **5.1 PROCEDURE FOR NEW STARTS OR INTERNAL MOVERS TO REGULATED ACTIVITY FROM NOVEMBER 2010**

This Section will be subject to review dependent on the outcome of the DHSSPS consultation exercises, and the implementation arrangements associated with financial issues.

The Trust's Recruitment Team will ensure that all employees who do not currently have ISA registration and who start employment on or after 1 November 2010 have ISA registration in place, with an EDC, before commencing employment. The financial implications associated with this are currently being discussed at a regional level to ensure consistency across the health and social care sector. This protocol will be amended as is appropriate to reflect the outcome of these discussions and agreements.

Once ISA registration is confirmed the Trust will register an interest in the individual with ISA to ensure that it is advised of any future information relevant to the individual's employment in regulated activity. The ISA registration number must be inputted to HRMS by the recruitment officer.

In relation to individuals who at the time of application are already ISA registered the Trust will ensure that it has the ISA registration number and has conducted an ISA on line check to verify this and must be satisfied that the individual is suitable for employment. The position with regard to the need for an EDC is to be confirmed and will be dependent on the nature of the post and the outcome of the DHSSPS consultation exercise.

In relation to individuals who already hold ISA registration at the point of application or transfer the registration number must be declared on the application form or, if not applicable, in writing to the HR officer dealing with the transfer – this could be associated with redeployment for example – and the Recruitment Team, or relevant HR officer, will complete an on line check with ISA to ensure that the individual is not barred from regulated activity and to register an interest in the individual. In the event that it is identified that an individual applying for a regulated activity post has been barred the HR Officer will ensure that the appropriate authorities, including the PSNI, are informed as the individual is committing a criminal offence.

Where an individual has been registered with a voluntary organisation the ISA will charge the individual upon notification that they have moved to paid employment or to voluntary work with the Trust as a public sector employer.



- Requesting Enhanced Disclosure Checks

In line with the Trust's Recruitment and Selection Policy managers are required to complete an Advertisement Request form in order to advertise a vacancy within the Trust and must indicate on the form if a pre-employment check is required under VBS - refer to appendix 3 of this procedure. This requirement also applies to the engagement of any volunteers or work placements within the Trust.

Applications for Enhanced Disclosures are made for applicants selected for appointment or transfer at the Trust's request or in line with mandatory requirements as appropriate. The application form used is a universal form for both ISA registration and EDC checks (see Appendix 5) and the application form must be signed by an approved signatory of the Trust – the Registered Body – and sent to ANI once the Applicant's identity has been verified. It should be noted that the Trust must indicate on the form that the post will involve working with children or vulnerable adults. It is only the nominated lead or countersignatories who can manage this Disclosure process and ensure that the necessary verification of the applicant's identification is carried out by the appropriate persons.

As a Registered Body the Trust must ensure that the Disclosure information is treated sensitively and confidentially and that it is protected from unauthorised access in line with its Statement of Intent and the ANI Code of Practice. All applicants and employees must be informed of this.

The Trust is required to make payment to ANI for the Disclosure Certificate and has an account with ANI to facilitate this. Both the Trust's signatory and the applicant receive copies of the Disclosure Certificate. ANI should process 90% of Enhanced Disclosures within 4 weeks.

It should be noted that sometimes applicants may seek to reuse their Disclosure Certificate as part of a separate recruitment exercise. The value of a Disclosure is directly linked to its contemporaneity. Enhanced Certificates should not be reused because every application to see spent convictions or approved information should be countersigned by a registered person on the basis of a specific role or position.

- Outcome of Checks

On receipt of a Disclosure Certificate the Trust must ensure that the Statement of Intent and Code of Practice is complied with and only those staff entitled to see Disclosures in the course of their duty should have access. In exceptional

circumstances the Police may provide additional information in a sealed envelope – this is only where the Police have identified a clear risk and such information must not be disclosed or discussed with the applicant. ANI will not be privy to the details of such information.

If it is confirmed that an individual's name is included on the barred lists they are disqualified from working in a regulated position and they will not be able to obtain ISA registration. If the individual is in the employment of the Trust and information is provided which indicates that there has been an issue of non-disclosure of previous offences by the employee then the appropriate action will be taken to investigate the matter under the Trust Disciplinary Procedure.

- Disputes and Disagreements

If an individual believes information disclosed about them is inaccurate they should follow the guidance set out at section 1.13 of the Guide to Access NI.

- Handling and Storage of Information

The Trust has a written Statement of Intent covering the correct handling and safekeeping of all documentation relating to an individual's disclosure information – appendix 2. It adheres to the ANI Code of Practice and guidance and its responsibilities under the Data Protection Act.

## **5.2 PROCEDURE FOR THE PHASED REGISTRATION OF EXISTING STAFF FROM APRIL 2011**

### **FOR STAFF WORKING IN:**

- Regulated Activity Positions

With effect from 1 April 2011 people already working in regulated activity may apply for ISA registration. The Trust will be introducing a phasing strategy in association with ANI to ensure that all relevant staff are ISA registered by 31 July 2015. The Trust will develop an implementation plan in relation to how this will be managed across professional and service groups and coordinated by HR.

- Controlled Activity Positions

With effect from 1 January 2014 people working in controlled activity should apply for ISA registration and by 31 July 2015 all such individuals must be ISA registered. The Trust will develop an implementation plan to ensure that this requirement is met.

- Other Positions

Students, trainees, placements and other non employees assigned to regulated/controlled positions within the Trust require to be checked. The checks may be undertaken by the Trust or alternatively by the sponsoring organisation depending on specific arrangements in place. Special arrangements apply to students in NI undergoing professional training whereby the University/College in NI is responsible for undertaking the check prior to the commencement of training. Examples include the following:

- Medical and Dental – Queens University Belfast
- Nursing and Midwifery – Queens University Belfast and University of Ulster
- Allied Health Professionals to include Dietetics, Physiotherapy, Occupational Therapy, Speech and Language, Podiatry, Radiography – University of Ulster
- Clinical Psychology – Queens University Belfast
- Pharmacy
- Optometry
- Dental Nurses (BMC)
- NNEB (Child care course (BMC))

These arrangements do not apply to Universities or Colleges outside NI or to students who are employees. Responsibility for checks on such students remains with the Trust. All other placements should be arranged through the Honorary Contract process prior to the commencement of the placement.

- Employment Agencies - .Arrangements will be put in place under the Trust's Safer Recruitment and Employment Framework and Safe Employment Practices Group to ensure that contracted agencies are compliant with the VBS Scheme.
- Staff employed by Private Contractors – .Arrangements will be put in place, in partnership with BSO to ensure that the relevant contractors are compliant with the VBS Scheme and meet the associated costs where appropriate.

- Executive and non-executive members of Health and Social Services Trusts. The checks will be undertaken by the DHSSPS.
- In relation to school children on work experience there is no requirement to register but there must be adequate supervision and compliance with the appropriate work experience protocol.
- Applicants from Outside the UK/Overseas –ANI is unable to obtain overseas criminal records. It can only provide details of offences committed in the UK. The Trust can consider examining the website of the Police Force of the country of origin or contact the country's representative in the UK. It can ask those with overseas residence to apply for the equivalent of a disclosure, if available.

In relation to these groups, the Trust must ensure that appropriate checks are being carried out and ensure that the appropriate arrangements under VBS are set out explicitly in any contract and that these are being adhered to. This should be reviewed on a regular basis.

## **6 REFERRALS TO ISA**

As a Regulated Activity Provider the Trust has a legal duty to refer information to the ISA in certain circumstances. With effect from 12 October 2009 a new duty to share information has been introduced under the Vetting and Barring Scheme and from this date employers, social services and professional regulators will have to notify the ISA of relevant information so that individuals who pose a threat to vulnerable groups can be identified and barred from working with these groups. ISA Referral Guidance has been developed and sets out the key elements of the new referral process, the circumstances under which a referral should be made, the legal responsibilities of employers and the main points of the law in relation to referrals.

The guidance is available at [www.isa.gov.org.uk](http://www.isa.gov.org.uk) and should be referred to when dealing with any referral issues. Advice and guidance **must** be sought from the Employment Law Team in Human Resources when dealing with a referral issue.

In dealing with referrals there are two conditions both of which must be met to trigger a referral to the ISA:

A referral must be made to the ISA when a regulated activity provider, such as an employer or volunteer coordinator or a responsible person in relation to controlled activity:

- 1) Withdraws permission for an individual to engage in regulated or controlled activity, or would have done so had that individual not resigned, retired, been made redundant or been transferred to a position which is not regulated or controlled activity; because
- 2) they think that the individual has:
  - engaged in relevant conduct;
  - satisfied the Harm Test; or
  - received a caution or conviction for a relevant offence

If both conditions have been met the information must be referred to the ISA

Definitions of these terms and guidance on the stage at which a referral should be made and the evidence to be provided are set out in detail in the guidance. The ISA referral form is appended as appendix 6 for information and Appendix 7 sets out the ISA guidance on types of harm.

In relation to the referral of individuals who are engaged by the Trust through an employment agency or who are placed with the Trust, for example through a university placement, the Trust must ensure that it informs these organisations, fully cooperates with them and ensures that they make a referral as appropriate in line with the Guidance.

## **7 GOVERNANCE ARRANGEMENTS**

This protocol will be kept under review to ensure compliance with any future legislative requirements. It will be reviewed formally on an annual basis and at appropriate periods where legislative changes occur. The Co Director for Governance, Employment Equality and Improving Working Lives will ensure that checking to ensure compliance is carried out by: -

- Seeking evidence from the Co Directors for Resourcing, Utilisation and Productivity (RUP), and Pay, Partnership and Employee Relations (PPE) that the Recruitment and Selection and Disciplinary Policies have been reviewed in light of any legislative or Departmental guidance developments.
- Seeking evidence from the Co Director for RUP on a six monthly basis that the requirements for the vetting of prospective staff are being conducted in line with this Protocol and associated guidance. This will involve

undertaking a sample of vetting conducted by the Trust's Recruitment team to ensure procedures are being followed.

- Seeking evidence from the Co Director for PPE on a six monthly basis that the process for referring any staff to the ISA has been conducted in line with this Protocol and associated guidance.
- Seeking evidence from the Co Director for RUP that any contracts with Private Contractors and Employment Agencies are compliant with the SVG Legislation and VBS and that monitoring arrangements are in place to ensure same.
- Seeking evidence from the Co Director for Learning and Development on a six monthly basis that all arrangements for Honorary Contracts are compliant with this protocol and associated guidance and that monitoring arrangements are in place to ensure same.
- The Co Director for Governance, Employment Equality and IWL will ensure that the audit arrangements set out in the Safer Recruitment and Employment Framework are implemented and reported on to the HR User Forum and any recommendations are taken forward.

June 2010

## APPENDIX 1

### **DEFINITION OF TERMS**

#### **Definition of Children and Vulnerable Adults**

For the purposes of this legislation the **definition of a child** is: -

- a person under the age of 18.

The **definition of a vulnerable adult** is a person who is aged 18 years or over and who:

- is living in residential accommodation, such as a care home or a residential special school
- is living in sheltered housing
- is receiving domiciliary care in their own home
- is receiving any form of healthcare
- is detained in lawful custody (in a prison, remand centre, young offender institution, secure training centre or attendance centre, or under the powers of the Immigration and Asylum Act 1999)
- is under the supervision of the probation services
- is receiving a welfare service defined as the provision of support, assistance or advice by any person, the purpose of which is to develop an individual's capacity to live independently in accommodation or support their capacity to do so
- is receiving a service or participating in an activity for people who have particular needs because of their age or who have any form of disability
- is an expectant or nursing mother living in residential care, or
- is receiving direct payments from a local authority or health and social care trust in lieu of social care services
- requires assistance in the conduct of their own affairs

Definitions of the key terms in the above list are provided in the Vetting and Barring Scheme Guidance, accessible at [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

#### **Regulated Activity**

A full definition of regulated activity is set out in the VBS guidance. In general terms an individual is involved in regulated activity if they:

Undertake an activity of a specified nature (ie teaching, training, instruction, care, supervision, advice, guidance, treatment, therapy or transport) that involves contact with children or vulnerable adults on a frequent, intensive or overnight basis.

Frequent is once a month or more (in health and personal care settings)

Intensive is four or more days in any period of 30 days or

Overnight is between 2 am and 6 am

OR

Undertake any activity in a specified place (ie schools, childcare premises including nurseries, residential homes for children, children's hospitals, children's detention centres, adult care homes or residential care or nursing homes) that provides the opportunity for contact with children or vulnerable adults on a frequent, intensive or overnight basis.

### **Controlled Activity**

Controlled activity is work that does not constitute regulated activity but which provides opportunities for contact with children or vulnerable adults, or opportunities to access education records (for children only) or health or social services records about children or vulnerable adults in a limited range of settings. It also includes the day to day management and supervision of staff carrying out controlled activity.

Controlled activity applies to:

- Work which is frequent or intensive and provides the opportunity for contact with children or vulnerable adults in health, social care or further education settings, or
- Work which is frequent and provides the opportunity to have access to education records (children only) or health or social services records (children and vulnerable adults) in specified bodies.

Frequent is once a month or more (in health and personal care settings), Intensive is four or more days in any period of 30 days.

Barred people can sometimes be employed in controlled activity, depending on the nature of the role and providing tough safeguards are in place such as stringent supervision. However, in Wales a person barred as a result of a caution or conviction for a relevant offence will not be able to work or volunteer in controlled activity.



**APPENDIX 2****Access NI Policy Statement**

As an organisation using Access Northern Ireland to help assess the suitability of applicants for positions of trust, the Belfast HSC Trust complies fully with AccessNI's Code of Practice regarding the correct handling, use, storage retention and disposal of Disclosure Applications and Disclosure information. It also complies fully with its obligations under the [Data Protection Act 1998](#) and other relevant legislation pertaining to the safe handling, storage, retention and disposal of Disclosure information.

**Storage and Access**

Disclosure information is be kept securely, in lockable, non-portable, storage containers with access strictly controlled and limited to those who are entitled to see it as part of their duties.

**Handling**

In accordance with section 124 of the Police Act 1997, Disclosure information is only passed to those who are authorised to receive it in the course of their duties. We maintain a record of all those to whom Disclosures or Disclosure information has been revealed and it is a criminal offence to pass this information to anyone who is not entitled to receive it.

**Usage**

Disclosure information is only used for the specific purpose for which it was requested and for which the applicant's full consent has been given.

**Retention**

Once a recruitment decision has been taken, we do not keep Disclosure information for any longer than is necessary. Information will not be retained but destroyed once a decision, recruitment or otherwise has been made.

**Disposal**

Once the retention period has elapsed, we will ensure that any Disclosure information is immediately destroyed by secure means i.e. by shredding, pulping or burning. While awaiting destruction, Disclosure information will not be kept in any unsecured receptacle (e.g. waste-bin or confidential sack). We will not keep any photocopy or other image of the Disclosure or any copy or representation of the contents of a Disclosure or any other relevant non-conviction information supplied by police but not included on the Disclosure. However, despite the above, we may keep a record of the date of issue of a Disclosure, the name of the subject, the type of Disclosure requested, the position for which the Disclosure was requested, the

AccessNI unique reference number of the Disclosure Certificate and the details of the recruitment decision taken.

### APPENDIX 3

## Online Job Requisition System

- [Home](#)
- [Log Off](#)
- [About](#)
- [Support](#)
  
- [My Home Page](#)
- [Search Requisitions](#)
- [Add Requisition](#)
- [My Profile](#)

### Requisition details

#### Job

Title

Has the post been verified (i.e. matched/desk topped)    
(if no please contact the recruitment team as the post can't proceed until desk topped)

Band

Other band

NIMDTA post

Location

Service group

Other service group

Department

Programme of Care

Other care programme

Possible Owners Please select the User who could approve the requisition at the next stage

Barkley , Mervyn

0 items selected [Remove all](#)

•

[Add all](#)

•

- **Barkley , Mervyn**
- **Beckett , Louise**
- **Milligan , Alma**
- **Owens , Bernie**
- **Peden , Joan**

### Costing

Cost Centre

### Source of funding

- New Post
- Replacement of fully funded post
- Other

Post detail

### Source of funding document

### Funding related documents

### Type of post

### Duration

- Permanent
- Temporary

Post detail

Covering who

Post vacancy from

End of temp contract

Possible extension

Yes

No

Hours per week

Times worked

**VBS DESIGNATION. Please advise if this post is a: (If you are unsure which of the following to select please contact a member of the recruitment team.)**

Controlled Post

Neither Regulated on Controlled Post

Regulated Post

VBS Designation Type.

Adult only


Children & Adult


Children only

Post advertisement

Advert placement **Please note this will be used as a guide only. The R&S team will determine final media in accordance with agreed protocol**

- Belfast Telegraph
- CSA Bulletin
- HSCRecruit/ HPSS Jobs
- Job Bulletin
- Job Market
- Limited internal trawl
- Offer from waiting list
- Other publication
- Trust wide internal trawl

Other advert placement > 

Any additional wording 

Panel chairperson

Chairperson telephone

Job description

Job/Person Specification

KSF Post Outline

TC Group

Grade Code

Comments

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[close](#)

**RISK ASSESSMENT OF POST FORM**

POST: \_\_\_\_\_ LOCATION: \_\_\_\_\_

This job has been identified as currently having the following key elements:-

	YES	NO	COMMENT
Driving as a <b>major</b> responsibility of the job			
Driving on Trust business as part of the working day			
Shift work			
Night duty			
On-call duties			
Regular use of a VDU ie. at least 1 hour/day or 5 hours/week			
Food handling			
Exposure to noise levels of 85dB or higher			
Direct contact with patients/clients			
Invasive (exposure prone procedures)			
Contact with blood/body fluids			
Manual handling of patients/clients			
Manual handling of inert objects			
Exposure to patients/clients with challenging behaviours which may include verbal and/or physical aggression			
Direct contact with patients/clients who are terminally ill			
Exposure to substances which might cause skin problems: Wet work			
<u>Disinfectant hand washes</u>			
Latex/rubber gloves			
Exposure to chemicals: Isocyanates			
<i>Formaldehyde</i> <i>Glutaraldehyde</i>			
Epoxyresins			
Methacrylates			
<i>Exposure to:</i>			
<i>Dust</i>			
<i>Soldering/welding fumes</i>			
<i>Soil</i>			
Exposure to substances not mentioned above which under the COSHH Regulations, require health surveillance to be carried out. Please state:			

Managers Signature: \_\_\_\_\_

Position: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OCCUPATIONAL HEALTH SERVICE USE ONLY**

RAP Form received and (Clients Name) \_\_\_\_\_ has been advised of the risks of this post.

Signed : \_\_\_\_\_ Date : \_\_\_\_\_



**APPENDIX 4**

TYPE OF POST	DESCRIPTION OF POST	WHAT IS REQUIRED	EXAMPLES OF POSTS WHICH MAY FALL IN THIS AREA (Please note this is not prescriptive – posts will have to be assessed against the descriptions of posts to determine the appropriate level of check)
Regulated Activity	<p>Any activity of a <b>specified nature</b> that involves contact with children or vulnerable adults frequently<sup>1</sup>, intensively<sup>2</sup> and/or overnight. Such activities include teaching, training, care, supervision, advice, treatment and transport etc</p> <p>Any activity allowing contact with children or vulnerable adults that is in a <b>specified place</b> frequently or intensively. (Such places include schools, care homes, residential homes, children’s centres, adult care homes etc). This may include catering, cleaning and maintenance workers or contractors, and their managers or supervisors.</p> <p>Fostering and childcare. And any activity that involves people in <b>certain defined positions</b> of responsibility. (Such as school governor, director of social services etc).</p>	<p>Enhanced Disclosure Certificates &amp; From July 2010 – new starts and internal movers <b>can register</b> with the VBS.</p> <p>From November 2010 new starts and internal movers <b>must be registered</b> with the VBS</p>	<ul style="list-style-type: none"> <li>• All Nursing &amp; Midwifery post;</li> <li>• All Social Care Posts (including Trust Domiciliary Care);</li> <li>• All Medical &amp; Dental staff;</li> <li>• All Allied Health Professionals;</li> <li>• All workers based in Children’s Homes, Residential or Nursing Homes;</li> <li>• Patient Transport Drivers;</li> <li>• Porters;</li> <li>• Pharmacists (<i>some posts may be controlled</i>);</li> <li>• Radiographer</li> <li>• Psychologist;</li> <li>• Orthoptists;</li> <li>• Othometrists</li> <li>• Dentistry Support</li> <li>• Medical Technical Officers (<i>some posts may be controlled</i>)</li> <li>• Art &amp; Music Therapists</li> <li>• Chaplains</li> <li>• Organists</li> </ul>
Controlled Activity	<p>Frequent<sup>1</sup> or intensive<sup>2</sup> <b>support work in general health settings</b>. (Such work includes cleaners, caretakers, shop workers, catering staff, car park attendants, receptionists etc). (<i>Note -Those on <u>specified sites</u> listed in the above section will continue to fall within regulated activity</i>)</p> <p>Individuals who have frequent<sup>1</sup> <b>access to sensitive records</b> about children and vulnerable adults.</p> <p><b>Support work in adult social care settings</b>. (Such jobs include day centre cleaners).</p>	<p>Enhanced Disclosure Certificates &amp; From 1<sup>st</sup> January 2014 – new starts and internal movers <b>can register</b> with the VBS From 31<sup>st</sup> July 2015 new starts and movers <b>must be registered</b> with the VBS.</p>	<ul style="list-style-type: none"> <li>• All Ancillary &amp; General Staff working in patient/client areas during operational hours unless otherwise provided for under ‘regulated activity’ above.</li> <li>• All Maintenance Staff working in patient / client areas during operational hours unless provided for under ‘regulated activity’ above.</li> <li>• All Financial Assessment staff</li> <li>• Cashiers Office</li> <li>• Biomedical Scientists</li> <li>• Clinical Scientists</li> <li>• Human Resources Case Management Staff</li> <li>• IT Staff working in patient/client areas during operational hours</li> <li>• Admin &amp; Clerical Staff in roles where they have direct access to patients/clients or their records</li> </ul>
Non Regulated or Controlled Activity	<p>Any worker who does not meet the definition of the Regulated or Controlled activity will not require to be registered with the VBS</p>	<p>Nothing</p>	<ul style="list-style-type: none"> <li>• HR Staff</li> <li>• Finance Staff</li> <li>• Ancilliary &amp; General Workers</li> <li>• Admin &amp; Clerical Staff</li> </ul> <p style="text-align: right;">} Other than those listed under controlled activity</p>

<sup>1</sup> Frequently – once a month or more

<sup>2</sup> Intensively – takes place on three or more days in a 30-day period

# **ISA – ACCESS NI APPLICATION FORM**

TO BE ADDED ONCE AVAILABLE FROM ACCESS NI

Trust Policy – Recruitment and employment of staff under the requirements of the safeguarding vulnerable groups.  
August 2010

BHSCT - E - 00033 – Protocol for Recruitment and Employment of staff under requirements of Safeguarding Vulnerable Groups\_2010.07\_ V1 (49 pages) – (00136) 32 of 49

BT Mod 3 Witness Stmt 20 Mar 2023 PART 4 OF 9 Exhibit Bundle (3 of 8) (T05-T06) 6536 of 8369  
(pp5404-8369 of 20966) (this part 2966 pages)

# APPENDIX 6 ISA Referral Form



Independent Safeguarding Authority

This form is for use when making a referral (i.e. providing information) to the Independent Safeguarding Authority. A referral is made when there is harm or risk of harm to children or vulnerable adults in the work place (paid or voluntary), *relevant conduct* has occurred or an individual has received a caution or conviction for a *relevant offence*.

Please read the accompanying *ISA Referral Guidance* to understand your duty in relation to making a referral to the ISA and in providing information requested by the ISA.

All information provided to the ISA will be handled in accordance with the Data Protection Act 1998.

Detailed information on the ISA and the Vetting and Barring Scheme can be found on the ISA website [www.isa.gov.org.uk](http://www.isa.gov.org.uk)

**Please download or print out this form and complete in black ink making sure that all information is clearly legible. All documents provided with the Referral Form should be originals or clearly legible copies. If you do not hold the information requested, please leave the section blank. If more space is needed please attach additional sheets at the back of the Referral Form.**

## Referral Form Information

**Part 1: The individual being referred and their job or role**

**Part 2: The referring party**

**Part 3: The harm (*relevant conduct*) or risk of harm**

**Part 4: Documentation - investigations, information & evidence**

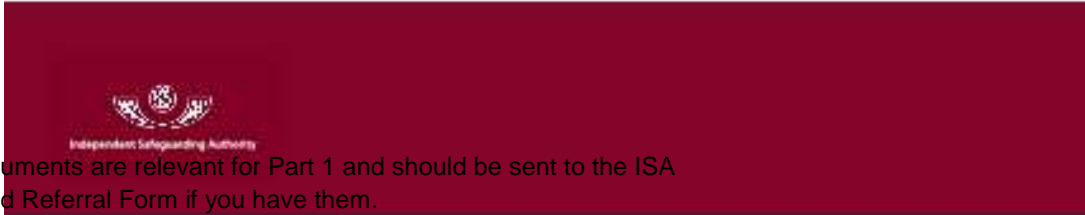
**Part 5: Referral documentation checklist**

**Part 6: Declaration by referring party**

**Part 7: Checking and posting the ISA Referral Form**

**Part 8: Data Protection Statement**

Part 1: The Individual being referred and their job role



- ◆ Job Description / Role Statement / Person Specification
- ◆ Application for employment
- ◆ References
- ◆ Interview report
- ◆ Letter of employment
- ◆ Documentation on any past disciplinary action or complaints
- ◆ Dismissal / resignation letters
- ◆ File notes concerning conduct, behaviour or attitude

Part 1: The Individual being referred

ISA Registration Number

Surname

Forename(s)

Title

Other names 1: aliases

Other names 2: maiden names

Gender (please indicate) - Male

Female

Date of Birth (DD/MM/YYYY)

Nationality

National Insurance Number

Teachers Pension Number

England and Wales (if applicable)

Northern Ireland Teacher Reference Number (if applicable)

Part 1: The Individual being referred and their job role Continued



**Professional Membership**

Professional Regulator

Registration Number

[Redacted registration number]

Date of first Registration (DD/MM/YYYY)

[Redacted date of first registration]

**Last Known Home Address**

Address Line 1

[Redacted address line 1]

Address Line 2

Address Line 3

Address Line 4

Postcode

[Redacted home address lines 2-4 and postcode]

**Current Postal Address** (if different from home address)

Address Line 1

Address Line 2

Address Line 3

Address Line 4

Postcode

[Redacted current postal address lines 1-2 and postcode]

**Previous Home Addresses** (if at last known address less than 3 years)

Address Line 1

Address Line 2

Address Line 3

Address Line 4

Postcode

[Redacted previous home address lines 1-4 and postcode]

**Contact Telephone Numbers**

Work

Home

Mobile

[Redacted contact telephone numbers]

[Redacted contact information]

Part 1: The Individual being referred and their job role Continued



The Individual being Referred's Job or Role

Title of Position Held

Date Appointed to the Position Held (DD/MM/YYYY)

[Redacted date field]

Main Duties/Responsibilities

[Redacted duties field]

Qualifications held by Individual

[Redacted qualifications field]

Training Undertaken by Individual in Current Post

[Redacted training field]

[Redacted field]

Part 1: The Individual being referred and their job role Continued



Training Undertaken by Individual in Previous Posts (if known)

[Empty rectangular box for training information]

Previous Employment / Volunteering History (if known)

Organisation	Job Title/Role	From (DD/MM/YY)	To (DD/MM/YY)
--------------	----------------	--------------------	------------------


History of any Misconduct, Disciplinary Action or Complaints (if known)

[Empty rectangular box for misconduct information]

Part 1: The Individual being referred and their job role Continued

Part 2: The Referring Party



If Still Employed / Volunteering - Current Job, Role and Duties



If No Longer Employed / Volunteering - Date Employment Ceased (DD/MM/YYYY)



Reason for Employment / Volunteering Ceasing (please tick one)

Dismissed

Resigned

Retired

Part 2: The Referring Party

Name of Referring Organisation/Person

Type of Organisation eg, School, Care Home etc  
(if school what category or type of school).



Address

Address Line 1

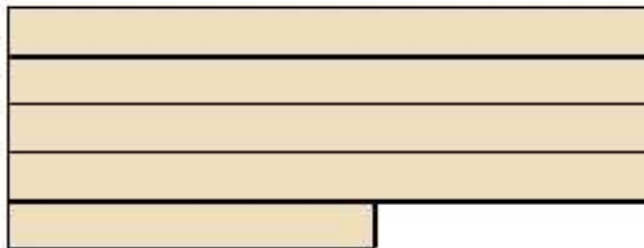


Address Line 2

Address Line 3

Address Line 4

Postcode



Primary Contact Officer

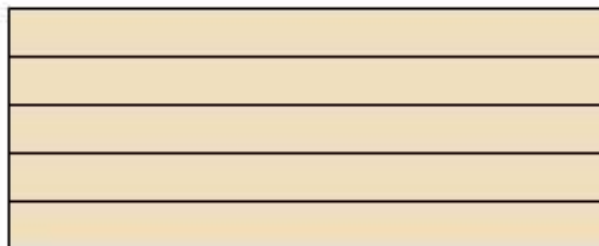
Name

Position

Telephone Number

Mobile Number

Email Address





Part 2: The Referring Party Continued

Part 3: The Harm (Relevant Conduct) or Why You Think there is a Risk of Harm



Alternative Contact Officer

Name

Position

Telephone Number

Mobile Number

Email Address

Redacted contact information fields.

Part 3: The Harm (Relevant Conduct) or Why You Think there is a Risk of Harm

The following documents are relevant for Part 3 and should be sent to the ISA with the Referral Form if you have them.

- ◆ Statement by the Referred Individual about what happened
- ◆ Harm Assessment Report

Please provide a brief summary of the *relevant conduct*, harm or risk of harm.

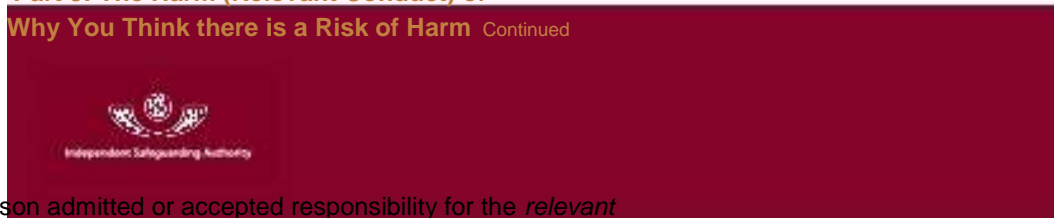
Redacted summary of relevant conduct.

Please provide details of the harm caused (or risk of harm) to the child or vulnerable adult and how this harm was assessed.

Redacted details of harm caused.

Redacted area at the bottom of the page.

**Part 3: The Harm (Relevant Conduct) or Why You Think there is a Risk of Harm** *Continued*



Has the referred person admitted or accepted responsibility for the *relevant conduct*, harm or risk of harm?

Yes

No

**Please provide details of the child or vulnerable adult harmed**

Name

Date of Birth (DD/MM/YYYY)

Or approx. age if DOB unknown

Gender (please indicate) - Male

Female

Details of any vulnerability, eg, emotional, behavioural, medical or physical

Relationship between referred person and person harmed

**Please attach additional sheets if more than one child or vulnerable adult harmed.**

**Part 3: The Harm (Relevant Conduct) or Why You Think there is a Risk of Harm** *Continued*



Please provide a chronology of events in relation to the harm (*relevant conduct*) or why you think the person you are referring may pose a risk of harm.

The chronology should provide in date and time order, a complete, clear and accurate description of what happened, what action has been taken and why. You need to be specific on details - dates, times, locations, what happened, who was involved who witnessed the event(s), who did what and who said what. When providing a chronology of events please refer to the ISA Referral Guidance for further information and see the example below.

**Example**

Date (DD/MM/YYYY)	Events	Relevant Documents	Persons Involved
01/01/2009	Allegation made against member of staff by colleague	Written allegation	Member of staff, Senior Manager
02/01/2009	Allegation put to individual	Individuals statement/ denied allegation	Individual, Senior Manager

Part 3: The Harm (Relevant Conduct) or Why You Think there is a Risk of Harm Continued



Chronology of Events

Date (DD/MM/YYYY)

Events

Relevant Documents

Persons Involved

## Part 4: Investigations, Information and Evidence



## Part 4: Investigations, Information and Evidence

In this section you are not required to provide any information other than the documents requested if you have them. The documents listed below are representative of the information required by the ISA in order to process your referral. If you have additional documentation you believe is relevant please include it and complete section 5 accordingly.

The following documents are relevant for Part 4 and should be sent to the ISA with the completed Referral Form if you have them.

- ◆ **Witness Statement(s)**
- ◆ **Harmed person's care plan (where appropriate)**
- ◆ **Details of internal investigations and outcome**
- ◆ **Details of internal disciplinary action and outcome**
- ◆ **Police investigations and reports**
- ◆ **Local Authority / Health and Social Care Trust investigations and reports including Adult Social Care and Children's Services reports and minutes of Strategy Meetings**
- ◆ **Investigations and reports of any other regulatory bodies**
- ◆ **Investigations and reports of any other agencies or bodies**
- ◆ **Victim Impact Report or statement(s) including details of who made the assessment and their position or qualifications to make the assessment**
- ◆ **Any other information either listed in the chronology or relevant to decision making by the ISA**

Part 5: Referral Document Checklist



Part 5: Referral Document Checklist

The following documents should be provided with the Referral Form if you have them.

Please tick all the documents (originals or clearly legible copies) that you are providing with this referral:

Job Description / Role Statement / Person Specification

Application for employment

References

Interview Report

Letter of Employment

Documentation on any past disciplinary action or complaints

Dismissal / resignation letters

File notes concerning conduct, behaviour or attitude

Statement by Referred Individual about what happened

Witness Statements

Harmed person(s) Care Plan

Details of internal investigations and outcome

Details of internal disciplinary action and outcome

Police investigations and reports

Local Authority investigations / Health and Social Care Trust Investigations and reports including Adult Social Care or Children's Services reports and minutes of Strategy Meetings

Investigations and reports of any regulatory bodies

Investigations and reports of any other agencies or bodies

Victim impact report or statement(s)

- Checkboxes for each document type

Part 5: Referral Document Checklist Continued



Please list any other relevant document(s) you are providing with the referral.

Large empty rectangular box for listing relevant documents.

Please list any relevant documents that you have/ or are aware of others having, but you are **not** providing with this referral. Please outline the reasons why you are **not** providing the document(s) and who has the document if it is not in your possession.

Relevant Document	Reason the document is not provided with this referral	Who holds this document

Part 6: Declaration

Part 7: Checking and Posting the ISA Referral Form

Part 8: Data Protection Statement

Part 6: Declaration



I confirm to the best of my knowledge that the information contained in this form is complete and accurate and that all relevant documents that I hold are either provided with the Referral Form or recorded in Part 5.

Signature

Name (in print)

Position

Organisation

Relation to individual being referred

Date (DD/MM/YYYY)

Form with multiple empty rows for signature and name details.

Part 7: Checking and Posting the ISA Referral Form

Please check that you have answered all the questions that you can on the ISA Referral Form, signed the Declaration and enclosed the documentary evidence you have listed in Part 5.

Post the completed ISA Referral Form and documentary evidence, suitably secured and marked CONFIDENTIAL to:

Independent Safeguarding Authority
PO Box 181
Darlington
DL1 9FA

Large empty rectangular box for address details.

Part 8: Data Protection Statement

The Independent Safeguarding Authority respects individual privacy and has notified (registered with) the Information Commissioner, who is responsible for the administration of the Data Protection Act 1998.

The Independent Safeguarding Authority obtains and processes "personal data" (as defined by the Act) for the purpose of administering its statutory functions under the Safeguarding Vulnerable Groups Act 2006 and associated legislation. In addition, the Independent Safeguarding Authority may use information for the purpose of fulfilling its statutory responsibilities under the Data Protection Act 1998.

Information will be kept secure and confidential, and will only be disclosed to those parties who have a legal and legitimate need to know.



## ISA Referral Guidance - Referral Policy

Type of harm to children	Meaning	Examples
<b>Emotional/ Psychological</b>	Action or inaction by others that causes mental anguish	Emotional harm is the emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. It may involve children witnessing aggressive, violent or harmful behaviour such as domestic violence. Some level of emotional harm is involved in all types of ill-treatment of a child, though it may occur alone. Grooming. Harassment. Inappropriate emotional involvement.
<b>Physical</b>	Any intentional physical contact that results in discomfort, pain or injury	Physical harm may involve assaults including hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Munchausen syndrome by proxy. Supply drugs to children. Inappropriate/unauthorised methods of restraint.
<b>Sexual</b>	Any form of sexual activity with a child under the age of consent	Sexual harm involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways. Downloading child pornography. Taking indecent photographs of children. Sexualised texting.
<b>Neglect</b>	Failure to identify and/or meet care needs	Neglect is the failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Source: Guidance Notes for the Barring Decision Making Process, ISA, February 2009

## ISA Referral Guidance - Referral Policy

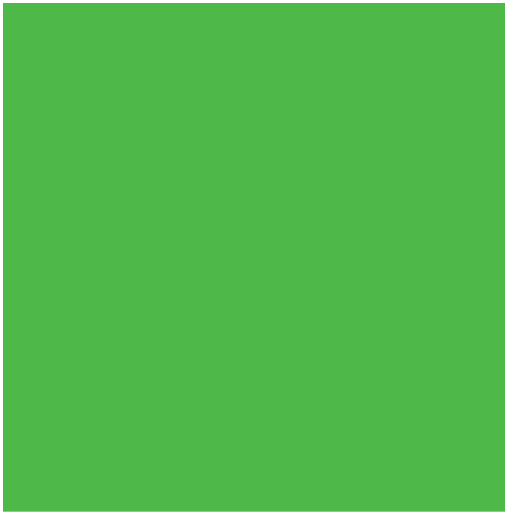
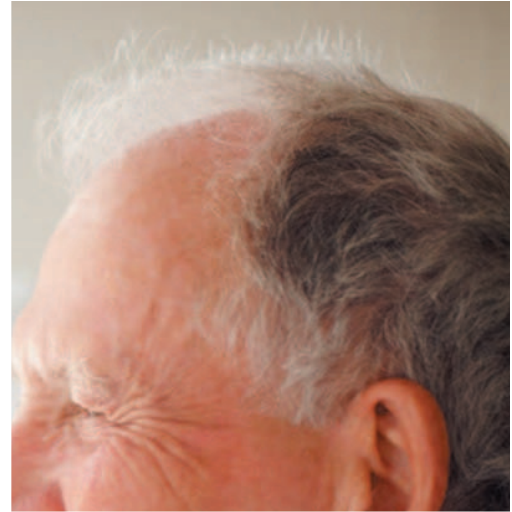
Type of harm to vulnerable adult	Meaning	Examples
<b>Emotional/ Psychological</b>	Action or inaction by others that causes mental anguish	Inflexible regimes and lack of choice. Mocking, coercing, denying privacy, threatening behaviour, bullying, intimidation, harassment, deliberate isolation, deprivation.
<b>Financial</b>	Usually associated with the misuse of money, valuables or property	Unauthorised withdrawals from vulnerable adult's account, theft, fraud, exploitation, pressure in connection with wills or inheritance.
<b>Physical</b>	Any physical action or inaction that results in discomfort, pain or injury	Hitting, slapping, pushing, shaking, bruising, failing to treat sores or wounds, under or overuse of medication, un-prescribed or inappropriate medication, use of restraint or inappropriate restraint, inappropriate sanctions.
<b>Sexual</b>	Coercion or force to take part in sexual acts	Inappropriate touching. Causing bruising or injury to the anal, genital or abdominal area. Transmission of STD.
<b>Neglect</b>	Failure to identify and/or meet care needs	Untreated weight loss, failing to administer reasonable care resulting in pressure sores or uncharacteristic problems with continence. Poor hygiene, soiled clothes not changed, insufficient food or drink, ignoring resident's requests, unmet social or care needs.
<b>Verbal</b>	Any remark or comment by others that causes distress	Demeaning, disrespectful, humiliating, racist, sexist or sarcastic comments. Excessive or unwanted familiarity, shouting, swearing, name calling.



# Safeguarding Vulnerable Adults

## A Shared Responsibility

Standards & Guidance for Good Practice  
in Safeguarding Vulnerable Adults





# Safeguarding Vulnerable Adults

## A Shared Responsibility

### Standards & Guidance for Good Practice in Safeguarding Vulnerable Adults

This is the first edition of this Guidance, published by Volunteer Now. The publication of this Guidance is supported by the Department of Health, Social Services and Public Safety.

#### **First Edition 2010**

This publication can be downloaded from our website - [www.volunteering-ni.org](http://www.volunteering-ni.org)

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Registered in Northern Ireland.



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The organisation has a safeguarding vulnerable adult policy supported by robust procedures.

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### Section 2

The organisation consistently applies a thorough and clearly defined method of recruiting staff and volunteers in line with legislative requirements and best practice.

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### Section 3

There are procedures in place for the effective management, support, supervision and training of staff and volunteers.

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### Section 4

The organisation has clearly defined procedures for raising awareness of, responding to, and recording and reporting concerns about actual or suspected incidents of abuse.

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### Section 5

The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding vulnerable adults.

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### Section 6

There are clear procedures for receiving comments and suggestions, and for dealing with concerns and complaints about the organisation.

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### Section 7

The organisation has a clear policy on the management of records, confidentiality and sharing of information.

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### Section 8

There is a written code that outlines the behaviour expected of all involved with the organisation, including visitors.

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## Appendices

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**All adults have the  
right to live a life  
free from abuse  
and exploitation.**



# Ministerial Foreword



We all have the right to lead the lives that we choose safe from abuse. Unfortunately there are times and circumstances where adults are exposed to exploitation, neglect and harm. We need to ensure that adults who are vulnerable receive all the assistance they need to keep them safe from harm and to be protected if harm occurs. Safeguarding vulnerable adults from harm is a shared responsibility. It is the responsibility of government to make sure there is a coherent policy framework that protects fundamental rights whilst ensuring that vulnerable adults are appropriately safeguarded. For organisations working with and delivering services to vulnerable adults there is a responsibility to ensure that services are safe and appropriate; and that abuse is recognised and responded to wherever it occurs. As citizens, we all have a duty of care to our family, friends and neighbours. Accordingly, we should be alert to and be prepared to take action about any concern that we might have about someone's frailty and vulnerability.

The development of *Safeguarding Vulnerable Adults – A Shared Responsibility*, as Guidance primarily for voluntary, community and independent sector organisations, is part of an ongoing programme of government activity to improve safeguards for vulnerable adults in Northern Ireland. This Guidance defines a standard of practice across a range of organisational activities deemed necessary to safeguard vulnerable adults from harm. It is designed to help organisations establish the minimum standard of practice required to reduce the risk of abuse of the vulnerable adults with whom they work. It defines the criteria considered necessary to meet that standard of practice and includes a range of resources, which I am certain organisations, large and small, will find invaluable.

I would ask you all to embrace this Guidance and to continue to work with us, to share the important responsibility of keeping adults, who are vulnerable, safe from harm.

A handwritten signature in blue ink, appearing to read 'Michael McGimpsey', with a small dot at the end.

**Michael McGimpsey**

Minister of Health, Social Services and Public Safety



# Introduction

In April 2009 the Department of Health, Social Services and Public Safety (DHSSPS) commissioned the Our Duty to Care (ODTC) team in the Volunteer Development Agency (Volunteer Now from April 2010) to develop standards and guidelines for organisations working with vulnerable adults in the voluntary, community and independent sectors. The introduction of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, combined with an increased awareness of adult abuse meant that the need for good practice guidelines for groups that work with vulnerable adults in those sectors became a priority.

With thirteen years experience of promoting good practice guidelines for organisations working with children, the ODTC team believed that safeguarding vulnerable adult guidelines should take account of the learning gained from the development of standards and guidelines to support organisations that work with children and young people.

However, the ODTC team was mindful of the fact that, while there are similarities between practice with children and vulnerable adults, there are significant differences and, to a large extent, greater complexity with regard to the latter. The scope of vulnerability, reflected in the definition of vulnerable adults, contributes to that complexity.

To ensure that the Guidance developed was applicable to a wide range of organisations, representing different vulnerable adult groups, a Safeguarding Vulnerable Adults Advisory Group was established comprising representatives from key voluntary, independent sector and statutory agencies with experience and expertise in their field. The project was also guided by the Regional Adult Protection Forum (the Forum) and guidance produced by the Forum in 2005, *Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance* and the associated Protocol for Joint Working. A debt of gratitude is owed to all those individuals who provided an enormous amount of information and text as well as support to the team. The membership and terms of reference of the Safeguarding Vulnerable Adults Advisory Group are provided in **Appendix 1**.

This Guidance contains 8 safeguarding standards and supplementary information. It is divided into 8 sections. Each section contains:

- **The Standard Statement;**
- **The criteria to meet the Standard;**
- **Supporting information for each criteria; and**
- **Resource material related to the Standard where referenced in the narrative.**

There are additional generic Appendices at the end of the Guidance which contain useful contact information, reference material and an organisational self-assessment checklist.



It is important to note that this document contains **minimum standards of practice for organisations**. Many small community and voluntary organisations have no Safeguarding Vulnerable Adult Policy and these organisations will benefit most from this Guidance. Organisations that are beginning to address the matter of safeguarding vulnerable adults will also find them valuable. Those organisations that provide Regulated Services will find that adherence to these standards will enable their compliance with the requirements for the Protection of Vulnerable Adults set out in the Minimum Standards published by the DHSSPS and in the Quality Assessment Framework under Supporting People.

Safeguarding Vulnerable Adults is a shared responsibility. In order to do this, we need to listen and stand alongside some of the most vulnerable people in our community. In addition, organisations need to work with the public to prevent abuse, where this is possible, and with each other to make sure that a sensitive and effective response is made to support individuals who may have been abused. This Guidance will contribute to the range of prevention, support and protection measures needed to meet the needs of vulnerable adults, their families and carers.

Adherence to this Guidance by organisations working with vulnerable adults in the voluntary, community and independent sectors will go some way to meeting that shared responsibility. Ultimately, our success will be determined by improved safeguarding outcomes for some of the most vulnerable adults in Northern Ireland.

Reasonable precautions have been taken to ensure information in this publication is accurate. However, it is not intended to be legally comprehensive; it is designed to provide guidance in good faith without accepting liability. If relevant, we therefore recommend you take appropriate professional advice before taking any action on the matters covered herein.

This Guidance is a living document. Changes to the document will be signposted on the Volunteer Now website and an updated version will be made available for download at: [www.volunteering-ni.org](http://www.volunteering-ni.org)

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“

**Good practice** means a commitment to keeping vulnerable adults **safe from harm and exploitation** and to upholding their rights.”

# Section 1



**The organisation has a safeguarding vulnerable adult policy supported by robust procedures.**

## Section 1

### Standard 1

**The organisation has a safeguarding vulnerable adult policy supported by robust procedures.**

#### Criteria:

1. The organisation has a written safeguarding vulnerable adult policy (a safeguarding policy) statement which: acknowledges that all adults have the right to live a life free from abuse and exploitation; outlines the organisation's commitment to uphold that right; and is explicit about the organisation's 'zero-tolerance' of abuse wherever it occurs.
2. The safeguarding policy should be 'owned' at all levels within the organisation. The Head of the organisation will direct the development of the policy, be responsible for its approval, and will ensure that it is fully implemented and reviewed.
3. The safeguarding policy statement should be clearly displayed and everyone involved with the organisation should be aware that the policy exists, what it aims to achieve and the steps that will be taken to achieve those aims.
4. The safeguarding policy should be supported by robust procedures and guidelines.
5. The safeguarding policy should be supported by a Code of Behaviour for all involved with the organisation, including visitors.
6. The safeguarding policy should be supported by other organisational policies and procedures aimed at promoting safe and healthy working practices.
7. The safeguarding policy, procedures, guidelines and Code of Behaviour should be subject to regular review to ensure that they are fit for purpose; a review at least once every three years is the minimum recommendation.

**1.1 The organisation has a written safeguarding vulnerable adult policy (a safeguarding policy) statement which: acknowledges that all adults have the right to live a life free from abuse and exploitation; outlines the organisation's commitment to uphold that right; and is explicit about the organisation's 'zero-tolerance' of abuse wherever it occurs.**

### Who is a vulnerable adult?

'A vulnerable adult is any person aged 18 years or over who is, or may be, unable to take care of him or herself or who is unable to protect him or herself against significant harm or exploitation. This may be because he or she has a mental health problem, a disability, a sensory impairment, is old and frail, or has some form of illness. Because of his or her vulnerability, the individual may be in receipt of a care service in his or her own home, in the community or be resident in a residential care home, nursing home or other institutional setting.'<sup>1</sup>

### Vulnerable adult rights

The rights of vulnerable adults to live a life free from neglect, exploitation and abuse are protected by the Human Rights Act 1998. Specifically, a vulnerable adult's right to life is protected (under Article 1); their right to be protected from inhuman and degrading treatment (under Article 3); and their right to liberty and security (under Article 5).

### See Resource 1.1 – Legal Context

As an organisation working with vulnerable adults, you will want to reassure them and their carers and advocates that your organisation is committed to good practice. Good practice means a commitment to keeping vulnerable adults safe from harm and exploitation and to upholding their rights; that is, always acting in their best interests and with their consent. Your safeguarding policy sets out how your organisation will do this.

Your organisation's practice and your safeguarding policy should be underpinned and guided by a number of values and principles as set out below.

### Values and Principles:

- **Access to information and knowledge** – all vulnerable adults will have access to information that they can understand to make an informed choice, including access to expert knowledge and advocacy, as required;
- **Choice** – all vulnerable adults will have the opportunity to select independently from a range of options based on clear and accurate information;
- **Confidentiality** – all vulnerable adults will know that information about them is managed appropriately and there is a clear understanding of confidentiality and its limits among staff/volunteers;

<sup>1</sup> This definition is from the leaflet entitled 'Adult Abuse – Guidance for Staff', published by the Northern Ireland Office and Department of Health, Social Services and Public Safety in 2009 and available from the nidirect website at [www.nidirect.gov.uk](http://www.nidirect.gov.uk). It is a working definition which reflects that contained in page 10 of the Safeguarding Vulnerable Adults Regional Adult Protection & Policy Procedural Guidance.

## Section 1

- **Consent** – all vulnerable adults have the right to be supported to make their own decisions and to give or withhold their consent to an activity or service. Consent is a clear indication of a willingness to participate in an activity or to accept a service. It may be signalled verbally, by gesture, by willing participation or in writing. No one can give, or withhold, consent on behalf of another adult unless special provision for particular purposes has been made for this, usually by law;
- **Dignity and respect** – all vulnerable adults will be accorded the same respect and dignity as any other adult, by recognising their uniqueness and personal needs;
- **Equality and diversity** – all vulnerable adults will be treated equally and their background and culture will be valued and respected;
- **Fulfilment** – all vulnerable adults will be invited to engage in activities and offered services that enable them to fulfil their ability and potential;
- **Independence** – all vulnerable adults will have as much control as possible over their lives whilst being safeguarded against unreasonable risks;
- **Privacy** – all vulnerable adults will be free from unnecessary intrusion into their affairs; and there will be a balance between the individual's own safety and the safety of others;
- **Safety** – all vulnerable adults will feel safe, and live without fear of violence, neglect or abuse in any form;
- **Support** – all vulnerable adults will be supported to report any form of abuse and to receive appropriate support following abuse for as long as may be required.

### See Resource 1.2 – Consent

It may seem obvious that the rights of vulnerable adults should be recognised and respected, but you must examine the policies and practices in your organisation by asking yourself if this is really the case. The way we work with vulnerable adults, how we behave around them and our attitudes towards them, all contribute to the way vulnerable adults feel about themselves. Induction, training and staff/volunteer development, which raise awareness of adult rights, the concept of adult abuse and how to respond to it, are essential to the delivery of your safeguarding policy aims and the creation of an environment where vulnerable adults are valued and their safety and well-being is paramount.

While such an environment will encourage vulnerable adults to disclose issues that are worrying them, it will also enable staff and volunteers to observe the demeanour and behaviour of vulnerable adults with whom they work or who are in their care, and to be alert to changes that may indicate abuse.

We know that abuse occurs in situations where another adult, sometimes a family member or friend or care worker, misuses a position of trust and power over a vulnerable adult. It is important, therefore, that vulnerable adults are made aware of their rights and sources of support and information which they can draw upon if they feel uncomfortable or threatened. This means sharing information with vulnerable adults; actively working towards raising their confidence; involving them in decision-making; taking their views and concerns seriously; and ensuring that those who have been abused receive support and protection from further abuse.

## What is a written safeguarding vulnerable adult policy statement?

A written safeguarding vulnerable adult policy statement (a safeguarding policy statement) appears at the beginning of the safeguarding policy. It should acknowledge the rights of vulnerable adults and make a clear commitment to uphold those rights by creating and maintaining an environment which aims to ensure, as far as possible, that adults who take part in activities or avail of the organisation's services are kept free from abuse and exploitation.

The safeguarding policy statement should be explicit about the organisation's zero-tolerance of abuse wherever it occurs or whoever is responsible. It should state how this will be done, by outlining the practical steps the organisation will take in the form of robust procedures supported by clear guidelines. It should be clear that the safeguarding policy applies to everyone involved with the organisation, including members of the management committee, managers and leaders, staff and volunteers, vulnerable adults and their carers, advocates and visitors.

## See Resource 1.3 – Sample Safeguarding Vulnerable Adult Policy Statement

### **1.2 The safeguarding policy should be 'owned' at all levels within the organisation. The Head of the organisation will direct the development of the policy, be responsible for its approval, and will ensure that it is fully implemented and reviewed.**

It is essential that your safeguarding policy is 'owned' at all levels within your organisation. To demonstrate an organisational commitment to keeping vulnerable adults safe from harm and exploitation, the Head of the organisation will direct the development of the policy, approve it and will ensure that it is fully implemented and reviewed at appropriate intervals. Depending on how your organisation is constituted, the Head of the organisation may be the Chief Executive; where the organisation is committee-led, the Chair of the Committee will act as Head of the organisation on behalf of the other Committee members. The safeguarding policy should be signed off by the Head of the organisation and the person(s) responsible for the review of the policy should be identified. In addition to a routine review of the safeguarding policy at agreed intervals, (at least once every three years is the minimum recommendation), the Head of the organisation may direct a policy review at any time in response to changes in the law or the organisation.

### **1.3 The safeguarding policy statement should be clearly displayed and everyone involved with the organisation should be aware that the policy exists, what it aims to achieve and the steps that will be taken to achieve those aims.**

The safeguarding policy statement should be prominently displayed in each of the organisation's facilities, and everyone involved with the organisation should receive or have access to a copy.



## Section 1

### Vulnerable adults, carers and advocates

While the safeguarding policy statement should be prominently displayed in the organisation's premises, vulnerable adults, carers and advocates should have access to the full safeguarding policy. If appropriate, information sessions on the safeguarding policy should be arranged. Attention will need to be paid to the provision of alternative formats where necessary, for example, large print.

### Staff and volunteers

Staff and volunteers, including managers and leaders, should be made aware of the safeguarding policy through initial induction training and vulnerable adult safeguarding training and should have easy access to a copy. Staff and volunteers should be encouraged to feed back on any areas of the safeguarding policy that need to be reviewed. Managers and leaders have a particular oversight and assurance role in relation to adherence to the policy by all involved with the organisation.

### Management group/committee

While the Head of the organisation is responsible for the approval of the policy, all members of the Senior Management Team or Management Committee should be fully aware of and understand their collective role and responsibility to deliver the safeguarding policy aims. Training may need to be provided to the Senior Management Team or Management Group/Committee members to help with their understanding of the safeguarding policy, its aims and their collective role and responsibility to ensure that it is fully implemented.

## 1.4 The safeguarding policy should be supported by robust procedures and guidelines.

Your organisation's vulnerable adult safeguarding procedures and guidelines will describe the practical steps that the organisation will undertake to deliver on the safeguarding policy aims. The Standards related to these procedures and guidelines are described in this Guidance at:

**Section 2:** Recruitment and selection of staff/volunteers;

**Section 3:** Management, support, supervision and training of staff/volunteers;

**Section 4:** Recognising, responding to, recording and reporting concerns about abuse;

**Section 5:** Risk assessment and management;

**Section 6:** Receiving comments and suggestions and management of concerns and complaints;

**Section 7:** Management of records, confidentiality and sharing of information.

## 1.5 The safeguarding policy should be supported by a Code of Behaviour for all involved with the organisation, including visitors.

Your organisation should draw up a Code of Behaviour to ensure that staff/volunteers are aware of the behaviour that is expected of them towards vulnerable adults, as well as those behaviours that are unacceptable. The Code of Behaviour should also outline how vulnerable

adults, carers and everyone involved with the organisation, including visitors, should relate to each other in a mutually respectful way. Further information can be found in:

**Section 8:** Code of Behaviour.

### **1.6 The safeguarding policy should be supported by other organisational policies and procedures aimed at promoting safe and healthy working practices.**

In addition to a safeguarding vulnerable adult policy, a 'healthy' organisation will have a range of organisational policies in place. These are necessary to ensure that your organisation is being properly managed, that the organisation's resources, both human and financial, are being used efficiently and effectively and that your practice will maintain public confidence. The other policies required will depend on the make-up of the organisation and the needs of the individuals with whom your organisation works. Some relevant additional policies are:

- Health and Safety;
- Moving and Handling;
- First Aid;
- Fire Safety;
- Equal Opportunities;
- Handling vulnerable adults' money;
- Bullying/Harassment;
- Domestic Violence and the Workplace.

**Note:** Organisations providing Regulated Services, that is, services which are registered with and inspected by the Regulation and Quality Improvement Authority (RQIA) will also need to take account of the regulations and associated Minimum Standards for these services.<sup>2</sup>

## **See Appendix 2 – Standards**

### **1.7 The safeguarding policy, procedures, guidelines and Code of Behaviour should be subject to regular review to ensure that they are fit for purpose: a review at least once every three years is the minimum recommendation.**

Your organisation's safeguarding policy, supporting procedures, guidelines and Code of Behaviour should be subject to periodic review. As a minimum, it is recommended that a review is conducted at least once every three years. However, an earlier review may be directed by the Head of the organisation, particularly in circumstances where changes to the law or to the organisation require it.

<sup>2</sup> At present Regulated Services include residential care homes; nursing homes; children's homes; independent clinics; independent hospitals; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres and day care centres. Up to date information about Regulated Services can be accessed through [www.rqia.org.uk](http://www.rqia.org.uk)

## Section 1

### Resource 1.1 Legal Context

Vulnerable adults are protected in the same way as any other person against criminal acts. If a person commits theft, rape or assault against a vulnerable adult s/he should be dealt with through the criminal justice system, in the same way as in cases involving any other victim. Where there is a reasonable suspicion that a criminal offence may have occurred, it is the responsibility of the police to investigate and make a decision about any subsequent action. The police should always be consulted about criminal matters.

There are a number of pieces of legislation relating to safeguarding and protecting vulnerable adults which can be accessed through [www.opsi.gov.uk](http://www.opsi.gov.uk)

Some of the relevant legislation is as follows:

#### **The Health and Personal Social Services (Northern Ireland) Orders and the Health and Social Care (Reform) Act (Northern Ireland) 2009**

The Health and Personal Social Services (NI) Order 1972 (the 1972 Order) as amended by the Health and Personal Social Services (NI) Order 1991, the Health and Personal Social Services (NI) Order 1994 and the Health and Social Care (Reform) Act (NI) 2009 (the Reform Act 2009) are key pieces of legislation governing the provision of health and social care in Northern Ireland.

The legislation imposes a number of duties including:

- a general duty to promote an integrated system of health and social care designed to secure improvement in the physical and mental health and social well-being of people in Northern Ireland;
- a duty to make arrangements, to such extent as the DHSSPS considers necessary, for the prevention of illness and the care and aftercare of a person suffering from illness;
- a duty to make available advice, guidance and assistance, to such extent as the DHSSPS considers necessary, and to make such arrangements and provide or secure the provision of such facilities as it considers suitable and adequate in order for it to discharge its duty to secure improvement in the social well-being of people in Northern Ireland;
- a duty on health and social services boards (now the Regional Health and Social Care Board under the Reform Act 2009) to make arrangements in respect of their area for the provision of personal medical services.

#### **The Mental Health (Northern Ireland) Order 1986**

The Mental Health (NI) Order 1986 (the 1986 Order) covers the assessment, treatment and rights of people with a 'mental disorder' defined in the Order as 'mental illness, mental handicap and any other disorder or disability of mind'. Learning disability has replaced the term mental handicap in current usage.

While most people with a mental disorder receive care and treatment in the community or in hospital on a voluntary basis, the Order sets out the criteria and process whereby a person may be compulsorily admitted to hospital and, subject to further criteria being met, treated without his or her consent.

The 1986 Order gives power to an Approved Social Worker (who is specially trained for the purpose) to make an application for admission to hospital for assessment in respect of a mentally disordered person. The 1986 Order also contains provisions in relation to the need for a person with mental illness or severe learning disability to receive the less restrictive means of assistance in the form of guardianship in a community care setting. Article 129 of the 1986 Order makes provision for a police officer to enter, if need be by force, any premises specified in a warrant authorised by a Justice of the Peace and remove to a place of safety a person believed to be suffering from mental disorder who (a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control; or (b) being unable to care for himself, is living alone.

The 1986 Order sets out offences in relation to the ill treatment or wilful neglect by staff of a patient who is receiving in-patient or out-patient care in a hospital, private hospital or nursing home. Similarly, offences apply to any individual who ill-treats or wilfully neglects a patient who is subject to guardianship under the 1986 Order or who is otherwise in his or her custody or care.

Article 107 of the Mental Health (NI) Order 1986, places a duty on a Health and Social Care (HSC) Trust to notify the Office of Care and Protection<sup>3</sup> if it is satisfied that any person within its area is incapable, by reason of mental disorder, of managing and administering his or her property and affairs. A similar duty is placed on a person carrying on a nursing home, a residential care home or a private hospital if s/he is satisfied that any person within his/her care is incapable, by reason of mental disorder, of managing and administering his property and affairs.

The Office of Care and Protection may appoint someone, who will have the authority to manage and administer a person's financial affairs. Such a person is called a Controller and is often a relative or close friend. If no relative or friend is willing or able to act, or because there is a disagreement between members of the family as to who should be appointed, the Master can order that the Official Solicitor be appointed as Controller. If circumstances change later the Court can direct a change of Controller. It is important to note that the Controller's authority relates only to finances and does not allow another individual to make welfare or medical decisions on another person's behalf.

Useful Leaflets published by the Office of Care and Protection can be accessed through [www.courtsni.gov.uk](http://www.courtsni.gov.uk)

### **The Police and Criminal Evidence (Northern Ireland) Order 1989**

Under the Police and Criminal Evidence (NI) Order 1989 it is a criminal offence to fail to disclose to the police any information about a suspected criminal offence.

Under this Order provision is made for 'an Appropriate Adult' to protect the interests of a mentally ill or impaired individual while in police detention. An 'Appropriate Adult' can assist, advise and support the vulnerable adult and is specially trained for this role.

### **The Disability Discrimination Act 1995**

The Disability Discrimination Act 1995 introduces new laws and measures aimed at ending the

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<sup>3</sup> The Office of Care and Protection is part of the Family Division of the High Court. It operates under the supervision of a Master, who is authorised to exercise any direction, power or other function of the court.

## Section 1

discrimination faced by many disabled people in the fields of employment; access to goods, facilities and services; and the management, buying or renting of property. The discrimination occurs when, for a reason related to an individual's disability, they are treated less favourably than other people to whom the reason does not apply, and this treatment cannot be justified.

It also applies when an employer or service provider fails to make a reasonable adjustment in relation to the disabled person, and the failure cannot be justified.

Further information on the Disability Discrimination Act 1995 can be obtained from [www.equalityni.org](http://www.equalityni.org)

### **The Race Relations (Northern Ireland) Order 1997**

The Race Relations (NI) Order 1997 outlaws discrimination on the grounds of colour, race, nationality or ethnic or national origin. The Irish Traveller community is specifically identified in the Order as a racial group against which racial discrimination is unlawful. The Race Relations Order makes direct racial discrimination, indirect racial discrimination and victimisation unlawful in the fields of employment; access to goods, facilities and services; education; and housing management and disposal of premises.

Further information on the Race Relations (NI) Order 1997 can be obtained from [www.equalityni.org](http://www.equalityni.org)

### **The Public Interest Disclosure (Northern Ireland) Order 1998**

The Public Interest Disclosure (NI) Order 1998 protects most workers who 'whistleblow' about wrongdoing in their place of work from suffering detriment from their employer for doing so. Detriment may take the form of denial of promotion or training or dismissal as a consequence of whistleblowing.

The Order sets out a list of situations, which if an employee discloses, should not result in detriment to them. Such situations would include criminal offences, or where there is a danger to the health and safety of individuals.

### **The Family Homes and Domestic Violence (Northern Ireland) Order 1998**

Domestic violence includes threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional), occurring between adults who are or have been intimate partners or family members.

The main purpose of the Family Homes and Domestic Violence (NI) Order is to consolidate the law on domestic violence and occupation of the family home.

Under this legislation, a Non-Molestation Order can be issued to prevent the perpetrator from threatening or using violence against the victim. A perpetrator can be forced to leave and stay away from a property by an Occupation Order so as to protect a victim.

### **The Northern Ireland Act 1998, Section 75**

Section 75 of the Northern Ireland Act 1998 requires public authorities designated for the purposes of the Act to comply with two statutory duties.

The first duty is the *Equality of Opportunity* duty, which requires public authorities in carrying out their functions relating to Northern Ireland to have due regard to the need to promote equality of opportunity between the nine equality categories of persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; men and women generally; persons with a disability and persons without and persons with dependants and persons without.

The second duty, the *Good Relations* duty, requires that public authorities in carrying out their functions relating to Northern Ireland have regard to the desirability of promoting good relations between persons of different religious belief, political opinion and racial group.

Section 75 aims to mainstream consideration of equality of opportunity and good relations in the policy development process. The statutory duties require more than the avoidance of discrimination. Public authorities should actively seek ways to encourage greater equality of opportunity and good relations through their policy development such as, for example, the kind of measures permitted under disability discrimination legislation.

Authorities should give particular consideration to positive action where the impact of a policy will affect different people in a different way, for example, the impact of a policy on people with disabilities. Authorities should take an approach which recognises that certain groups such as people with disabilities may experience higher levels of inequalities than non-disabled people.

The Equality Commission for Northern Ireland recommends that authorities, as part of the policy development process, effectively assess the equality implications of a policy through screening of all policies for equality impact and undertaking an equality impact assessment where appropriate.

Public authorities must consult on screening decisions and equality impact assessments with stakeholders, including those directly affected by the policy.

Further information on Section 75 of the Northern Ireland Act 1998 can be obtained from [www.equalityni.org](http://www.equalityni.org)

### **The Criminal Evidence (Northern Ireland) Order 1999**

The Criminal Evidence (NI) Order 1999 introduced the right for vulnerable adults to give evidence in cases via video link.

### **The Human Rights Act 1998 – enacted 2000**

The Human Rights Act 1998 came into effect in 2000 and makes the European Convention on Human Rights part of the law of Northern Ireland. It allows individuals and organisations to go to court or tribunal to seek redress if they believe that the rights conferred on them by the European Convention have been violated by a public authority. The Human Rights Act says that persons carrying out certain functions of a public nature will fall within the definition of a public authority. The courts are still deciding exactly what this means. In any event, following human rights standards, even in matters not strictly covered by the ambit of the Human Rights Act, will be good practice. It should be noted that Section 145 of the Health and Social Care Act 2008 extended the coverage of the Human Rights Act to residents in residential care and nursing homes where their care has been contracted for by HSC Trusts.

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There are 16 Articles in the Human Rights Act. The following have the most relevance to safeguarding and protecting vulnerable adults:

- **Article 2 Right to Life**

Everyone's right to life will be protected by law. This places a positive obligation on public authorities to act in a manner which reduces the risk of harm (including death) to individuals. For example, if staff were aware of an abusive situation and did not take any action to prevent it, and the individual died as a result of the abuse, it could be argued that the authority had failed in respect of its positive duty under Article 2.

- **Article 3 Prevention of Inhuman or Degrading Treatment**

No one will be subjected to torture or to inhuman or degrading treatment or punishment. This places a positive duty on public authorities to prevent inhuman or degrading treatment by others, e.g. a care worker mistreating a person using health or social care services. If the public authority was aware of the abuse and did not take steps to prevent this, it could be argued that it had failed in respect of its positive obligations under Article 3.

- **Article 5 Liberty and Security of Person**

This is about the right to freedom. No one should have their freedom of movement restricted without good reason. In terms of safeguarding vulnerable adults, this has implications for actions such as seclusion, restraint, 'locked door' policies and use of medication. There is a positive obligation on public authorities to intervene to prevent abusive situations in relation to these occurring.

- **Article 6 Right to a Fair and Public Hearing**

Everyone has the right to liberty and security of person. No one will be deprived of liberty unless in accordance with a procedure prescribed in law. This is relevant in terms of equality of access to justice for vulnerable adults. It was one of the drivers behind the development of the Criminal Evidence (NI) Order 1999 and the Protocol for Joint Investigation of Alleged and Suspected Incidents of Abuse of Vulnerable Adults.<sup>4</sup>

- **Article 8 Right to a Private and Family Life**

Everyone has the right to a private and family life without interference, except in accordance with the law. A positive duty is also placed on public authorities to ensure others do not infringe the individual's Article 8 rights.

- **First Protocol - Article 1 Protection of Property**

A person has the right to the peaceful enjoyment of their possessions. Public authorities cannot usually interfere with things people own or the way they use them, except in specified limited circumstances. In the vulnerable adult context, this has implications for the prevention of financial abuse.

- **First Protocol - Article 2 Right to Education**

No person will be denied the right to an education. Vulnerable adults therefore have the same right to education as everyone else. This has implications, for example, for adults with learning difficulties in terms of their right to sex education.

Further information about human rights can be accessed through [www.nidirect.gov.uk](http://www.nidirect.gov.uk)

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<sup>4</sup> The protocol can be accessed through [www.hscboard.hscni.net](http://www.hscboard.hscni.net)

## **The Health and Personal Social Services Act (Northern Ireland) 2001**

The Health and Personal Social Services Act (Northern Ireland) 2001 (the 2001 Act) established the Northern Ireland Social Care Council (NISCC) to regulate the social work profession, and other social care workers, in line with the introduction of similar bodies in England, Scotland and Wales. The 2001 Act also sets out NISCC's functions with regard to regulating the education and training of social workers.

It is the duty of the Council to promote (a) high standards of conduct and practice among social care workers; and (b) high standards in their training. Among other things, NISCC is required to maintain a register of social workers and social care workers; and from time to time publish codes of practice laying down (i) standards of conduct and practice expected of social care workers; and (ii) standards of conduct and practice in relation to employers of social care workers.

Individuals have a right of appeal against a decision of NISCC not to register them or to remove them from the register. Appeals are heard by an independent Care Tribunal.

## **The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003**

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the 2003 Order) is part of a framework designed to raise the quality of services provided to the community and tackle issues of poor performance in health and social care provision. Among other matters, the 2003 Order:

- Established the Regulation and Quality Improvement Authority (RQIA), an independent body, with overall responsibility for monitoring, regulating and reporting on the quality of health and social care services delivered in Northern Ireland;
- Gave RQIA responsibility for and powers to regulate a wide range of care services including many services (establishments and agencies) which had previously been unregulated and many services delivered by the Health and Social Care sector as well as services delivered by the voluntary, community and independent sectors;
- Introduced a common system of regulation based on Minimum Standards set out by the DHSSPS, and supported by a programme of registration and inspection; and
- Reconstituted the main appeals tribunal used by this and other legislation.

The 2003 Order also provides for an appeal against a decision of RQIA in relation to the regulation of establishments and agencies ("Regulated Services"). Appeals are heard by an independent Care Tribunal.

## **The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007**

The Safeguarding Vulnerable Groups (NI) Order 2007 and equivalent legislation in England, Wales and Scotland establishes new safeguarding arrangements across the UK aimed at strengthening protection for children and vulnerable adults in workplace situations.

Key features of the new arrangements, known as the Vetting and Barring Scheme (VBS), include:

- The establishment of a new Independent Safeguarding Authority (ISA), which will register those working with children and vulnerable adults and maintain lists of those barred from such work on the basis of harm or risk of harm;



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- A requirement for employees (both paid and unpaid) working in specified positions to register with the ISA and pay a registration fee;
- A requirement for employers to check whether an individual working in specified positions is registered with the ISA prior to employing them. This may be done by way of an on-line check;
- Phased ISA registration of the existing children's and vulnerable adults' workforces;
- Continuous monitoring of those registered with the ISA;
- A requirement for employers, professional registration bodies and inspection authorities to refer relevant information to the ISA; and
- Offences for not meeting the requirements created by the legislation.

The VBS will go-live in phases. You can keep up to date with developments through [www.isa-gov.org.uk](http://www.isa-gov.org.uk)

### **The Sexual Offences (Northern Ireland) Order 2008**

The Sexual Offences (NI) Order 2008 provides a new legislative framework for sexual offences, including offences against people with a 'mental disorder', as defined in the Mental Health (NI) Order 1986. Articles 43 – 46 relate to offences against people who cannot legally consent to sexual activity because of a mental disorder.

The Order sets out clear parameters for people working with vulnerable adults and sets strong penalties for offenders.

The 'position of trust' offences, already in law in Northern Ireland under the Sexual Offences Act 2003 have been re-enacted without any change. Articles 51 – 57 contain new offences for people who are engaged in providing care, assistance or services to vulnerable adults. It also provides clarity for the police and courts.

Under the Order, any sexual activity between a care worker (which includes doctors, nurses and social workers) and a person with a mental disorder is prohibited whilst that relationship of care continues, whether or not the victim appears to consent and whether or not they have the legal capacity to consent. Friends or family members who provide care, assistance or services to the vulnerable adult also fall within the scope of the Order.

## Resource 1.2 Consent

An organisation that provides activities and services for vulnerable adults should adhere to the Values and Principles set out in Section 1.1 of this Guidance. In so doing, you will seek always to work in the best interests of the vulnerable adult and with his/her consent. Staff/volunteers should always be mindful of the need for vulnerable adults to consent to, and to be comfortable with, any proposed activity/service.

Consent is a clear indication of a willingness to participate in an activity or to accept a service. The vulnerable adult may signal consent verbally, by gesture, by willing participation or in writing. Decisions with more serious consequences will require more formal consideration of consent and appropriate steps should always be taken to ensure that consent is valid.

Staff and volunteers should remember that no one can give, or withhold, consent on behalf of another adult unless special provision for particular purposes has been made for this, usually in law. In certain situations the need for consent may be overridden. This is generally when it is in the public interest to do so, for example, the disclosure of information to prevent a crime or risk to health or life.

**If you have any concerns about consent, for example, doubts about whether it has been given or whether it is valid, you should always contact your Line Manager or Nominated Manager (see Section 4.2), who should in turn seek professional advice where necessary.** Similarly, if you have any concerns about a vulnerable adult's ability to consent, especially if s/he is agreeing to an activity or relationship within or outside the organisation that may be abusive, you should report your concerns immediately in line with the arrangements set out in Section 4 of this Guidance.

### How do I obtain the consent of a vulnerable adult?

Those who work with adults, including vulnerable adults, should be aware of the need for consent to be considered in all circumstances, including those relating to taking part in straightforward activities or accepting services offered. Obtaining consent does not mean that a signature on a form is necessary on every occasion. Consent is a process - it results from understanding through dialogue and the provision of information. Consent may be expressly given; alternatively it may be signalled by a person's conduct. For example, a vulnerable adult may signal his/her consent to participate by turning up at the Tuesday luncheon club voluntarily; or, in a care context, by willingly going with a staff member to get bathed or dressed.

As a general rule, the method of obtaining consent is likely to be dictated by the seriousness of what is being proposed. The more serious the proposal and the consequences of agreeing to it might require that the vulnerable adult is asked to sign a form. This would be appropriate, for example, in circumstances where a vulnerable adult in a residential care home is being asked to agree to transfer to a nursing home where his or her needs will be better served. Such decisions should involve health and social care professionals, and possibly a more formal assessment of consent.

It does not matter so much how a vulnerable adult shows consent, whether this is by way of signing a form, or saying, or indicating by another means that s/he agrees. The important issue is to ensure the consent given is valid.

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### When is consent valid?

The consent of a vulnerable adult is considered valid **only** if:

1. S/he has the capacity to consent, that is, s/he can understand and weigh up the information needed to make the decision; **and**
2. Sufficient information has been given to him or her, in an appropriate way, on which to base the decision; **and**
3. Consent has been given on a voluntary basis, that is free from coercion or negative influence.

### **If any of these three factors is absent, consent cannot be considered to be valid.**

It may be possible to intervene in the life of a vulnerable adult who cannot give valid consent but only in very particular circumstances, for very specific purposes and in accordance with laws governing this kind of intervention. This includes the common law of necessity, under which Accident and Emergency staff may need to treat an individual, who is unconscious, for the purpose of saving his or her life.

**As indicated above, if you have any concerns or doubts about whether the consent of a vulnerable adult is valid, you should bring this to the attention of your Line Manager or Nominated Manager, who should seek professional advice where necessary.** In Regulated Services, the care plan completed on referral should address any issues about consent that might affect day to day living. This should be kept under continuous review.

## Resource 1.3 Sample Safeguarding Vulnerable Adult Policy Statement

A safeguarding vulnerable adult policy statement is a statement of your intention to keep vulnerable adults safe while in the care of your organisation.

It should be a simple statement, which reflects the nature and activities of your organisation such as:

### Our commitment to safeguard

Abuse is a violation of an individual's human and civil rights; it can take many forms. The staff and volunteers in (organisation name) are committed to practice which promotes the welfare of vulnerable adults and safeguards them from harm.

Staff and volunteers in our organisation accept and recognise our responsibilities to develop awareness of the issues that cause vulnerable adults harm, and to establish and maintain a safe environment for them. We will not tolerate any form of abuse wherever it occurs or whoever is responsible. We are committed to promoting an atmosphere of inclusion, transparency and openness and are open to feedback from the people who use our services, carers, advocates, our staff and our volunteers with a view to how we may continuously improve our services/activities.

We will endeavour to safeguard vulnerable adults by:

- Adhering to our safeguarding vulnerable adult policy and ensuring that it is supported by robust procedures;
- Carefully following the procedures laid down for the recruitment and selection of staff and volunteers;
- Providing effective management for staff and volunteers through supervision, support and training;
- Implementing clear procedures for raising awareness of and responding to abuse within the organisation and for reporting concerns to statutory agencies that need to know, while involving carers and vulnerable adults appropriately;
- Ensuring general safety and risk management procedures are adhered to;
- Promoting full participation and having clear procedures for dealing with concerns and complaints;
- Managing personal information, confidentiality and information sharing; and
- Safeguarding vulnerable adults by implementing a code of behaviour for all involved with the organisation, including visitors.

We will review our policy, procedures, code of behaviour and practice at regular intervals, at least once every three years.

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<b>Author:</b>	
<b>Publication date:</b>	
<b>Approved by:</b>	
<b>Effective from:</b>	
<b>For attention of and action by:</b>	Members of the Senior Management Team, Management Committee/Group; managers and leaders; staff and volunteers; vulnerable adults; carers and advocates; and visitors.
<b>Review date:</b>	
<b>Nominated Manager:</b>	(Name and Contact details)

# Section 2



**The organisation consistently applies a thorough and clearly defined method of recruiting staff and volunteers in line with legislative requirements and best practice.**

## Section 2

### Standard 2

**The organisation consistently applies a thorough and clearly defined method of recruiting staff and volunteers in line with legislative requirements and best practice.**

#### Criteria:

1. There is a clear job description for staff and role description for volunteers and a personnel/volunteer specification outlining the key skills and abilities and qualifications, if any, required.
2. There is an open recruitment process.
3. There is an application form that covers past work/volunteering.
4. There is a declaration and consent form requesting information on previous convictions and investigations, if any.
5. There is an interview process suitable to the post/role and task.
6. Written references are sought (and followed up when necessary).
7. If a professional qualification is a requirement of the post, a registration check is made with the appropriate Professional Regulatory Body.
8. Where required, an AccessNI disclosure check and/or a check of Independent Safeguarding Authority registration is carried out.
9. The post is approved by management.

## **2.1 There is a clear job description for staff and role description for volunteers and a personnel/volunteer specification outlining the key skills and abilities and qualifications, if any, required.**

It is important to have good recruitment and selection procedures to minimise the opportunity for unsuitable people to work or volunteer with vulnerable adults. The procedures outlined below apply whether you are recruiting staff or volunteers.

The first step is to define the job or volunteer role. This involves thinking through what exactly you consider the job/role to be, identifying what skills will be required of them and being clear about the qualities required to fill the post. For a staff post this will be outlined in a job description and for a volunteer, in a role description. The qualifications, if any, skills and qualities required of the member of staff/volunteer will be described in a personnel specification for an employee and in a volunteer specification for a volunteer.

The job and role descriptions should indicate whether the post constitutes regulated or controlled activity under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 (SVG NI Order 2007). Under the SVG NI Order 2007, there is a legal requirement to check that an individual who works in regulated activity is a member of the Vetting and Barring Scheme (VBS), established under the SVG NI Order 2007.

### **See Resource 2.1 – The Vetting and Barring Scheme**

## **2.2 There is an open recruitment process.**

In addition to the job/role description and personnel/volunteer specification, detailed recruitment material should be drawn up outlining the activities and aims of the organisation. Posts should be advertised widely – this may be at regional level for paid posts and at a more local level for volunteer roles, but will depend on the nature of the post/role and the organisation.

## **2.3 There is an application form that covers past work/volunteering.**

An application form should be supplied along with a clear job/role description and personnel/volunteer specification. Information about the organisation should be included, as well as a copy of the organisation's safeguarding statement. The application form should be drafted to allow applicants to provide all relevant details and should include a written assurance that all information received will be dealt with confidentially.

### **See Resource 2.2 – Sample Employment Application Form**

### **See Resource 2.3 – Sample Volunteer Application Form**

When recruiting staff, organisations providing services regulated by the RQIA must ensure that they comply with the regulatory requirement in relation to the service they provide. With regard to the 'fitness of staff' this generally requires that:

- They are of integrity and good character;



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- They have the qualifications, skills and experience for the work they are to perform;
- They are physically and mentally fit for the work they have to perform; and
- Full and satisfactory information, as specified in regulations, is available in relation to them.

### **2.4 There is a declaration and consent form requesting information on previous convictions and investigations, if any.**

All applicants should be asked to sign a declaration and consent form and declare any past (including 'spent') criminal convictions, cautions and bind-over orders and cases pending against them. The reason for this is to ensure that the information provided by the applicant concurs with the information that appears on the Enhanced Disclosure Certificate.

The applicant should also be asked to provide information on any investigation that has been carried out in relation to vulnerable adult abuse in which they have been the alleged perpetrator, and to agree to further enquiries being made, relevant to the declaration.

Organisations should make it clear that such information will be dealt with in a confidential manner and will not be used unfairly.

#### **See Resource 2.4 – Declaration and Consent Form**

### **2.5 There is an interview process appropriate to the post/role and task.**

At least two representatives of the organisation should conduct the interview (or meeting in the case of a volunteer) at which you should assess the information contained in the application form against the kinds of qualities and skills needed for the post. You should take this opportunity to gauge the candidate's understanding of vulnerability, abuse and safeguarding to ensure that s/he is able and committed to meet the standards set out in this Guidance.

An acceptable form of identification, ideally a form of photographic identification such as a passport or driving licence, and, where required, documentary evidence of qualifications and any accredited training should be produced by the candidate at the interview.

### **2.6 Written references are sought (and followed up when necessary).**

References should be taken up in writing with at least two people who are not family members and ideally, one of whom should have first hand knowledge of any previous work the applicant has undertaken with vulnerable adults. A more accurate and reliable reference will be achieved by asking specific questions on the reference form. In particular, referees should be asked to confirm that they have no concerns about the applicant working with vulnerable adults.

#### **See Resource 2.5 – Sample Employee Reference Request Form**

#### **See Resource 2.6 – Sample Volunteer Reference Request Form**

## **2.7 If a professional qualification is a requirement of the post, a registration check is made with the appropriate Professional Regulatory Body.**

The job description should also indicate whether registration with a Professional Regulatory Body, e.g. the Northern Ireland Social Care Council (NISCC), Nursing and Midwifery Council (NMC), Health Professions Council (HPC) is required and this should be checked.

### **See Appendix 3 – Professional Regulatory Bodies**

## **2.8 Where required, an AccessNI disclosure check and/or a check of Independent Safeguarding Authority registration is carried out.**

If an individual is seeking work in regulated activity with vulnerable adults, there is a legal requirement to check whether s/he is a member of the VBS, established under the SVG NI Order 2007.

Individuals seeking work in regulated activity, who are not already members of the VBS, will have to apply to become members, that is, register with the Independent Safeguarding Authority (ISA). Applications for ISA registration are processed by AccessNI and will include a check of criminal conviction/caution information, relevant intelligence information held by the police and checks against the lists of individuals barred from working in regulated activity held by the ISA. Applications, which are countersigned by the 'employing' organisation, should be supported by identity checking as outlined in the AccessNI Code of Practice.

Individuals who are already members of the VBS can be checked by way of a free on-line check. Again, on-line checking should be supported by robust identity checking using the range of documents recommended in the AccessNI Code of Practice.

Services regulated by RQIA will require a Standard or Enhanced Disclosure Check on proprietors, managers and staff. Enhanced and Standard Disclosure Certificates can be obtained on application from AccessNI and should be requested in line with the AccessNI Code of Practice.

### **See Resource 2.7 – AccessNI**

## **2.9 The post is approved by management.**

All posts should be approved by management. It is not the responsibility of any individual member of staff or volunteer to appoint a new staff member or volunteer, but an organisational responsibility.

### **And finally...**

Safeguarding vulnerable adults must be a primary consideration in developing a thorough method of recruiting, selecting and managing staff and volunteers. However, there are other matters that you should consider in order to enhance the quality of care provided to vulnerable adults in your organisation. The make-up of your staff and volunteers should be responsive to the needs of the vulnerable adults with whom you work or who are in your care.

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Some things to consider are:

- Your obligations as an employer/volunteer organisation to adopt a policy of non-discrimination within the terms of equality legislation;
- Attempting to attain, as far as possible, an appropriate balance of male and female staff/volunteers;
- Attempting to attain, as far as possible, staff/volunteers who are reflective of any minority cultural or linguistic groups represented in your membership.

## Resource 2.1 The Vetting and Barring Scheme

The Vetting and Barring Scheme (VBS) is being implemented under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 (SVG NI Order 2007). This Order replaces the Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003 (POCVA) and the vetting and barring arrangements under POCVA. The aim of the VBS is to prevent unsuitable individuals obtaining work with both children and/or vulnerable adults.

The VBS is a membership scheme where anyone over the age of 16 who has significant contact (expressed in terms of frequency and intensity – see below) with a vulnerable group, through the course of their employment or volunteering, will be checked and registered with the Independent Safeguarding Authority (ISA) before they take up post/role.

The duty for individuals to register with the ISA will apply to those who work and volunteer with children and vulnerable adults in specified activities, in specified places and in specified positions and to those who manage and supervise them in the course of their duties. AccessNI will perform the function of processing VBS applications.

Work with children and vulnerable adults is expressed in terms of ‘regulated activity’ and ‘controlled activity’. These terms, combined with conditions of ‘frequency’, ‘intensity’ and ‘opportunity for contact’ define the scope of the VBS. <sup>5</sup>

### What is regulated activity?

<b>Regulated Activity</b>	
Involves contact with children or vulnerable adults and is:	
of a <b>specified nature</b> e.g. care, advice, treatment, or transport teaching, training, etc.	<b>Frequently</b> <ul style="list-style-type: none"> <li>Once a week for most services but once a month or more for health and social care services involving personal care <sup>6</sup> or providing assistance with a vulnerable adult’s finances. <sup>7</sup></li> </ul>
OR	
is undertaken in a <b>specified place</b> e.g. schools, children’s homes, children’s hospitals, juvenile detention facilities, adult care homes, etc.	<b>Intensively and/or overnight</b> <ul style="list-style-type: none"> <li>Intensively: takes place on 4 days in one month or more</li> <li>Overnight: between 2am and 6am</li> </ul>
OR	
is a <b>specified post</b> e.g. school governors, chief executives and members of key education, health and social care bodies, the Commissioner for Children and Young People, etc.	
<b>No distinction made between paid and voluntary work</b>	

<sup>5</sup> Following the examination of the scope of the VBS by Sir Roger Singleton in late 2009, proposals which relate to the continuance or otherwise of controlled activity are the subject of public consultation.

<sup>6</sup> Personal care includes the provision of appropriate assistance in counteracting or alleviating the effects of old age and infirmity, disablement, past or present dependance on alcohol or drugs, or past or present mental disorder and includes action taken to promote rehabilitation, assistance with physical or social needs and counselling.

<sup>7</sup> Assistance with finances means having access to the service user’s money whether that is by using cash or cards where, for example, a care worker provides assistance with shopping or paying bills.

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### What is controlled activity?

Controlled activity is work, which is less substantive than regulated activity but which provides opportunities for contact with children or vulnerable adults, or opportunities to access education records (for children only) or health or social services records about children or vulnerable adults in a limited range of settings. The key difference between regulated and controlled activity is that employers will be able to employ someone barred from regulated activity to carry out controlled activity, provided they put in place appropriate safeguards. At the time of writing this Guidance, a consultation is underway which is considering the continuance of controlled activity under the VBS.

### What is meant by a vulnerable adult for the purpose of the VBS?

The definition of a vulnerable adult for the purpose of the VBS is summarised in the table below.

<b>Vulnerable Adult</b>	
Any person over age 18 and over who:	
<ul style="list-style-type: none"> <li>receives any form of health care;</li> <li>lives in residential accommodation including sheltered housing;</li> <li>receives domiciliary care;</li> <li>receives support, assistance or advice to help them live independently;</li> <li>requires assistance in the conduct of their own affairs</li> <li>receives a direct payment;</li> <li>is an expectant/nursing mother in residential accommodation.</li> </ul>	<b>Health and Social Care</b>
<ul style="list-style-type: none"> <li>receives any service or participates in activity provided specifically because of disability or particular age-related needs.</li> </ul>	<b>Sport, Faith, Voluntary and Community Sector Provision</b>
<ul style="list-style-type: none"> <li>is detained in lawful custody; or</li> <li>is on probation.</li> </ul>	<b>Justice</b>

### What does the VBS require and provide for?

The VBS will:

- Require individuals who work in regulated activity to become members of the VBS, that is, register with the ISA. Currently, the cost of registering with the ISA is **£58** (in most cases, there will be no charge for volunteers who apply to join the VBS). In Northern Ireland, applications will be processed by AccessNI. Further details on registration with the ISA, including commencement dates, can be found on the ISA website at: [www.isa.gov.org.uk](http://www.isa.gov.org.uk)
- Require employers and volunteer managers to check whether someone is a member of the VBS, that is, ISA registered. Employers and volunteer managers will be able to check by way of an on-line facility, which is **free of charge**. Further information about on-line checking can be found on the ISA website.

- Require employees or volunteers, who are included in a barred list, **not** to seek or obtain work in regulated activity.
- Require employers and volunteer managers **not** to offer work or volunteering opportunities in regulated activity to individuals who are included in a barred list.
- Continuously monitor individuals who are ISA registered. Any further information that comes to light as a result of continuous monitoring will be provided to the ISA and potentially trigger barring decision-making.
- Enable employers and volunteer managers to register an interest in employees and volunteers in whom they have a legitimate interest so that they can be informed if the ISA is minded to bar an individual, that is, include him or her on a barred list or when the individual's status within the VBS changes.
- Require employers, volunteer managers, professional regulation and inspection bodies, and child and adult protection teams to refer individuals who have harmed or placed at risk of harm a child or vulnerable adult to the ISA. The ISA will consider individuals referred to it for inclusion on one or both of its barred lists. The requirement to refer to the ISA started on **12 October 2009**. Further information on how to refer and in what circumstances is available in ISA referral guidance and fact sheets, which are available for download from the ISA website. Individuals who are being considered for barring by the ISA will be able to make representations to the ISA; they will also be able to appeal to the Care Tribunal against an ISA decision on the grounds that a mistake has been made on a finding of fact or a point of law.
- Automatically bar individuals who have been convicted or cautioned for very serious offences against children or vulnerable adults. A list of automatic barring offences will be available from the ISA website.

## Section 2

### Resource 2.2 Sample Employment Application Form

#### Application Form

Candidate Reference Number	
<b>JOB TITLE</b>	Return to

<b>PERSONAL DETAILS</b> (Please complete using block capitals and black ink)			
Surname		Forename	
Address			
		Postcode	
Home Tel No		Work Tel No	
Mobile No			
May we contact you at work?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Email Address			
Where did you see the vacancy advertised?			

<b>CURRENT OR MOST RECENT EMPLOYER</b>			
Name			
Address			
Postcode		Tel No	
Position held and brief outline of duties			
Date Started		Date Left	
Reason for leaving			
Job Title		Salary	
Notice Period (if applicable)			

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<b>PREVIOUS EMPLOYMENT</b> Please give details of employment (paid or unpaid) over the last 10 years. <b>Please give your most recent first.</b>				
Name & Address of Employer and nature of business	Dates of employment		Position Held	Reason For Leaving
	From	To		

<b>EDUCATION</b> Please give details of all qualifications obtained, along with grade and date achieved. <b>Please give your most recent first.</b>				
Name & Address of School/ College/University	Dates		Course details and exam results	Date Obtained
	From	To		

<b>PROFESSIONAL QUALIFICATIONS</b> (Held or working towards)				
Professional Body/ College/University	Dates		Course details and exam results	Date Obtained
	From	To		



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<b>SPECIALISED TRAINING OR COURSE ATTENDED</b>			
Course Taken	Organised By	Location	Date

<b>MEMBERSHIP OF PROFESSIONAL BODIES</b> Please give details of membership or any professional duties			
Name of Professional Body (e.g. NMC, NISCC, HPC)	Level/type of membership	Registration Details (e.g. Part of Register)	Expiry Date

<b>SUPPORTING INFORMATION</b> (Please ensure when completing this section that you demonstrate that you meet the short listing criteria)
Experience
Knowledge

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Ability
Qualifications

<p><b>REFERENCES</b> Please give details of two referees; one must be your current or most recent Line Manager or school or college. References from family or friends are not acceptable.</p>			
REFERENCE 1		REFERENCE 2	
Name		Name	
Job Title		Job Title	
Organisation		Organisation	
Address		Address	
Postcode		Postcode	
Tel No		Tel No	
Email Address		Email Address	

<p><b>DECLARATION OF CONVICTIONS</b></p> <p><b>See attached - Declaration and Consent Form</b></p>
--

<p><b>DECLARATION OF HEALTH</b></p>		
<p>Do you consider yourself to have a disability?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>
<p>If yes, please give brief details below of the effects of the disability on your day to day activities, and any other information that you feel would help us to accommodate your needs and thus meet our obligations under the Disability Discrimination Act:</p>		

## Section 2

<p><b>DECLARATIONS</b> Please ensure you sign and date this declaration before returning your application form.</p>
<p><b>DATA PROTECTION ACT DECLARATION</b> - The information on the application form will be held and processed in accordance with the requirements of the Data Protection Act 1998.</p> <p>I understand that the information is being used to:</p> <ul style="list-style-type: none"> <li>• Process my application for employment;</li> <li>• Form the basis of a computerised record on the recruitment system for processing and monitoring purposes;</li> <li>• Form the basis of a manual job file with other application forms and will be used for processing;</li> <li>• If appointed, form the basis of a manual and computerised employment record.</li> </ul>
<p>I declare that the information provided on this form is true and complete to the best of my knowledge and belief. I understand that any false or omitted information may result in dismissal or other disciplinary action if I am appointed.</p> <p>Signature _____</p> <p>Date _____</p> <p><b>Please note:</b> All information received will be dealt with in confidence, consistent with our commitment to safeguard vulnerable adults.</p>

**Resource 2.3 Sample Volunteer Application Form**

**Volunteer Application Form**

<b>Name of organisation:</b>	
Address:	
Town:	Postcode:
Tel No:	

Please note that the information given below will be used to try to match potential volunteers to the most appropriate roles available at the time of application to volunteer with *[name of organisation]*.

Name:			
Address:			
Postcode:			
Home Tel No:		Work Tel No:	
May we contact you at work? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Mobile No:			
Email Address:			

Please tick the volunteer roles that you would be interested in:

Role Title 1  Role Title 2  Role Title 3  etc

*(Or list Geographical area/sites available to volunteer in).*

When would you be available to volunteer with us? *(Please tick)*

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning							
Afternoon							
Evening							

What motivated you to apply for a volunteer role in (name of organisation)?


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What previous work experience, including voluntary work do you have?


Do you have any hobbies or interests?


What skills, knowledge and experience do you feel you could bring to a voluntary role in our organisation?


We at *(name of organisation)* aim to be an inclusive and supportive organisation. In accordance with Disability Discrimination Act 1995, a person is considered to have a disability if s/he has 'a physical or mental impairment which has a substantial and long term adverse effect on a person's ability to carry out normal day to day activities.' Please note it is the effect of the impairment, without treatment, which determines if an individual meets this definition of disability.

Do you consider that you meet this definition of disability?

YES  NO

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Are there reasonable adjustments that we could make as part of your recruitment process that would enable you to enjoy equality of opportunity in getting a volunteer role with us?  
Please specify:


Please provide names and addresses of two people who we could contact for a reference.  
(Someone who is not a relative, but has known you for 2 years within the last 5 years.)

<b>1. Name:</b>	<b>2. Name:</b>
Address:	Address:
Post Code:	Post Code:
Work Tel No:	Work Tel No:
Home Tel No:	Home Tel No:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for your interest, we will be in touch soon.  
Please return completed form to:  
Volunteer Organiser, *(name of organisation)*

**Please note:**  
All information received will be dealt with in confidence, consistent with our commitment to safeguard vulnerable adults.

## Section 2

### Resource 2.4 Declaration and Consent Form

We are committed to safeguarding vulnerable adults and to ensuring equal opportunity for all applicants. Information about criminal convictions is requested to assist the selection process and will be taken into account only when the conviction is considered materially relevant to the position applied for.

You have applied for a position that is defined as Regulated Activity under the Safeguarding Vulnerable Groups (NI) Order 2007. It also falls within the definition of an 'excepted' position under the Rehabilitation of Offenders (Exceptions) Order (NI) 1979. This means that you **must** tell us about **all** offences and convictions, including those considered 'spent'.

If you have received a formal caution or are currently facing prosecution for a criminal offence you should also bring this to our attention given the "excepted" nature of the role. If you leave anything out it may affect your application.

This information **will** be verified through an AccessNI **Enhanced Disclosure Check (EDC)** if you are considered to be the preferred candidate and are being offered the position. The EDC will tell us if you have a criminal record or if your name has been included on the Children's Barred List and/or Adults' Barred List. It is to make sure that individuals who are considered a risk to vulnerable adults and/or children are not appointed.

The information received will be treated confidentially and will be assessed alongside normal selection criteria to determine suitability for the position. A separate meeting will be held with you if clarification is required to discuss any issues around your disclosure before a final decision is reached. After the decision has been made the information will be destroyed.

Please complete the attached form and return it with your application. The form also asks you to give your written consent to the AccessNI EDC and to agree to further enquiries being made relevant to the declaration, which will only be obtained if you are the preferred candidate. If you do not consent we will not accept your application.

## Declaration of Criminal Convictions, Cautions and Bind-Over Orders

### In Confidence

<b>Do you have any prosecutions pending?</b> (if yes give please give details)	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>

<b>Have you ever been convicted at a court or cautioned by the police for any offence?</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
If yes, please list below details of all convictions, cautions, or bind-over orders. Give as much information as you can, including, if possible, the offence, the approximate date of the court hearing and the court which dealt with the matter.		

<b>Declaration of Abuse Investigation(s)</b>
Have you ever been the subject of an Adult or Child Abuse investigation which alleged that you were the perpetrator of any adult or child abuse?
<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
If yes, please list full details below including the name of police unit or HSC Trust involved in the investigation. If possible please provide the approximate date/s.

### Declaration and Consent

I declare that the information I have given is complete and accurate. I understand that I will be asked to complete an AccessNI Disclosure Certificate Application Form if I am considered to be the preferred candidate and I consent to the Enhanced Disclosure Check being made, and I agree to inquiries relevant to this declaration.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Any surname previously known by: \_\_\_\_\_

Position applied for: \_\_\_\_\_



**Section 2**

**Resource 2.5 Sample Employee Reference Request Form**

**Reference Request Form**

**In Confidence**

Name of applicant			
Position applied for			
1	In what capacity do you know the applicant, e.g. line manager, supervisor, professional colleague?		
2	How long have you known the applicant?		
3	Length of Service	Start Date	End Date
4	Reason for leaving		
5	Most recent position held		
6	Summary of main duties		
7	Please comment on the following areas, being as specific as possible		
	<ul style="list-style-type: none"> <li>• Applicant's main strengths</li> </ul>		
	<ul style="list-style-type: none"> <li>• Areas for improvement</li> </ul>		
	<ul style="list-style-type: none"> <li>• Applicant's ability to meet the competencies and skills of the post (see job description)</li> </ul>		
8	If you have had any concerns about any aspects of his/her work, please detail		

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9	Please detail any particular supervision or support needs that the applicant may have had if different to above
10	Has the applicant been subject to any formal action in relation to discipline or competence at any time? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please give details	
11	Has the applicant had a satisfactory attendance record? Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, please give details	
12	Please state days of sickness absence over the past 2 years
13	Do you have any concerns about the applicant's suitability to work with vulnerable adults? Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, please give details	

Under the Data Protection Act, I am aware that this reference may be made available to the applicant, if requested.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Position Held \_\_\_\_\_

Organisation/Business \_\_\_\_\_

Tel No \_\_\_\_\_ Email Address \_\_\_\_\_

**Note:** We may contact you to clarify any of the information provided.



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4 Please rate this person on each of the following? (please tick one)

	Poor	Average	Good	V/Good	Excellent
Responsibility					
Maturity					
Self motivation					
Can motivate others					
Commitment					
Energy					
Trustworthiness					
Reliability					

As an organisation committed to safeguarding vulnerable adults, we need to know about the applicant's suitability to work with vulnerable adults.

Do you have any concerns about the applicant's suitability to work with vulnerable adults?

Yes  No

If Yes, please give details


**Note:** We may need to contact you to clarify any of the information provided. Please indicate a convenient time for us to do this:

Under the Data Protection Act I am aware that this reference may be made available to the applicant, if requested.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Tel No \_\_\_\_\_

Email Address \_\_\_\_\_

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### Resource 2.7 AccessNI

AccessNI assists organisations in Northern Ireland to make more informed recruitment decisions by providing criminal history information about anyone seeking paid or unpaid work in defined areas, such as working with vulnerable groups. AccessNI operates under Part V of the Police Act 1997 and is part of the Department of Justice. AccessNI has replaced the POC (NI) and POVA (NI) services provided by the Department of Health, Social Services and Public Safety.

An **Enhanced Disclosure Check (EDC)** provides criminal record information from across the UK, including spent convictions, barred list information and any relevant non-conviction information held by the police and other enforcement agencies. From 12 October 2009, positions defined as **regulated activity** with children or vulnerable adults as defined by the SVG NI Order 2007, are checked at an EDC level.

Individuals apply for an EDC using the AccessNI application form. This application must be countersigned by a **Registered Body**.

Organisations wishing to countersign applications and receive a copy of the Enhanced Disclosure Certificate for potential staff and volunteers need to register with Access NI. Registration forms can be downloaded from the AccessNI website (address below) and the cost of registration is £150. The process takes approximately four weeks and, once registered, the organisation becomes a Registered Body. Organisations which do not wish to register directly with AccessNI can apply for an EDC through an **Umbrella Body**, details of which can be obtained from the AccessNI website.

EDCs for volunteers are free except: where the volunteering is directly for a statutory organisation; or in a specific project for which that organisation has received funding from Government, which includes provisions covering the cost an EDC for volunteers. For all other applications a cost of £30 is required.

AccessNI will perform the function of registering those who work with children or vulnerable adults in Northern Ireland with the **Independent Safeguarding Authority**. This will be done using the existing network of registered and umbrella bodies. ISA registration will cost £58 in Northern Ireland, but is free for those who qualify for free AccessNI EDCs.

#### See Resource 2.1 – The Vetting and Barring Scheme

For further information on AccessNI, visit [www.accessni.gov.uk](http://www.accessni.gov.uk)

# Section 3



**There are procedures in place for the effective management, support, supervision and training of staff and volunteers.**

## Section 3

### Standard 3

**There are procedures in place for the effective management, support, supervision and training of staff and volunteers.**

#### Criteria:

1. There is an induction process into:
  - The organisation; and
  - The post/role.
2. There is a probationary period for staff and trial period for volunteers.
3. Relevant training is provided appropriate to the post/role.
4. There is a robust structure and process for support and supervision appropriate to the post/role.
5. There is an annual appraisal for staff and review for volunteers.
6. Comprehensive, written records are kept of: training completed; support and supervision; and annual appraisals.

**3.1 There is an induction process into:**

- **The organisation; and**
- **The post/role.**

Good management of staff and volunteers will ensure that everyone in the organisation is clear about what the organisation is trying to achieve and what their particular roles are. A thorough induction process is integral to good organisational practice. It ensures that staff/volunteers are properly prepared for their work and reduces anxieties associated with starting a new post/role. Organisations working with vulnerable adults should ensure they have an induction process in place for staff/volunteers.

Induction should take place when a new staff member or volunteer starts with your organisation. It should be well planned and its format explained to the new worker. It should include:

- Information on organisational policies, procedures, guidelines, activities and ethos;
- What is expected and required of them and the boundaries or limits within which they should operate;
- Awareness raising and training on the recognition, recording and reporting of abuse;
- Meeting co-workers and relevant Line Managers;
- Information about key stakeholders and their roles;
- Practical information such as breaks, the location of the kitchen and toilets, etc.

The Northern Ireland Induction Standards are required to be implemented from 1 April 2008 by employers of individuals for whom registration with the NISCC is a requirement. For individuals not required to register with NISCC, the standards are suggested as best practice.<sup>8</sup>

Induction will ideally be done over a few days as new staff/volunteers can only take in a certain amount of information at a time. A timeframe should be set within which induction should be completed. Staff/volunteers should be asked to acknowledge that they have completed induction training and have read and understood the organisation's policies, procedures and guidelines.

With the increasing number of people entering the workforce from outside Northern Ireland, employers should take account of cultural sensitivities. Some cultural awareness raising may be required for employers and existing staff/volunteers to minimise misunderstandings. Awareness raising for staff/volunteers from outside Northern Ireland may be required on what is considered acceptable and unacceptable practice within the established culture here. This should be part of the initial induction programme. Guidance on cross cultural issues may be obtained from the Multicultural Resource Centre.

**See Appendix 4 – Useful Contacts**

To ensure that everything necessary is covered at induction, it is good practice to have an Induction Checklist. It is also useful for organisations to put together a handbook of information covered at induction to give to staff/volunteers for reference.

**See Resource 3.1 – Sample Induction Checklist**

<sup>8</sup> NISCC has developed a resource for managers who are implementing induction and a workbook for new staff to help them plan and record their progress towards completing induction. These materials are available through [www.niscc.info](http://www.niscc.info)



## Section 3

### 3.2 There is a probationary period for staff and trial period for volunteers.

Appointments of staff and volunteers should be conditional on the completion of a satisfactory period of work i.e. a probationary period for employees and a trial period for volunteers. A minimum period should be established at the time of employment/involvement e.g. three to six months. During this time you should pay particular attention to the work of the individual and his/her attitude to and aptitude for working with vulnerable adults. A record should be made of any matters arising during the probationary/trial period and any training needs identified.

At the end of the probationary/trial period it is good practice to have a review of the staff member's/volunteer's progress in post/role. In cases where there are concerns about a staff member's/volunteer's performance, it may be necessary to extend their probationary/trial period, or to terminate their services altogether. Any decision made at this stage should not come as a surprise if regular support and supervision has been carried out.

### 3.3 Relevant training is provided appropriate to the post/role.

Apart from induction, staff and volunteers should receive training, including safeguarding vulnerable adult training, appropriate to their work. This training should be reviewed and updated regularly in line with changing legislation and practice. It is recommended that update training takes place at least every three years, unless otherwise stipulated in the Minimum Standards relevant to your service area. A good understanding of the nature of vulnerable adult abuse is essential to help staff/volunteers to be alert to signs that a vulnerable adult may have been abused.

#### See Appendix 2 – Standards

Safeguarding vulnerable adult training should include a basic awareness and understanding of the factors which contribute to vulnerability; the possible signs of vulnerable adult abuse; responding when abuse is disclosed or suspected; recording and reporting procedures; and what is meant by confidentiality in the context of adult safeguarding. Staff/volunteers should be trained to take concerns about adult abuse seriously; to deal with information about alleged or suspected abuse sensitively; to know never to make promises to keep secrets; to understand that their role is not to investigate; and to know how to report concerns about alleged or suspected abuse and how to contact a Line Manager or Nominated Manager if they are in any doubt whatsoever (see Section 4).

#### See Resource 3.2 – Sample knowledge set of key learning outcomes when training staff/volunteers on safeguarding vulnerable adults

Other relevant training should be provided on, for example, equal opportunities, communication skills; partnership working with carers; dealing with challenging behaviour; and training particular to the needs of the vulnerable adults, such as understanding dementia. The type of training required will depend very much on the profile of the vulnerable adults with whom you work.

All organisations should have a Code of Behaviour for staff/volunteers outlining the behaviour expected and behaviours to be avoided when working with vulnerable adults in the organisation. Staff/volunteers should have training on the Code of Behaviour and should also have an input into its regular review. Guidelines on drawing up a code of behaviour can be found in Section 8. Professionally qualified staff will be required to adhere to a professional code of practice, which will be available from their Professional Regulatory Body's website.

#### See Appendix 3 – Professional Regulatory Bodies

### **Analysing staff and volunteers' skills and training needs**

Developing an effective training programme requires an assessment of the skills, knowledge and experience of each staff member or volunteer to identify training gaps. This will, of course, differ between individuals. It is best practice to keep a record of training needs, training provided, date provided and how useful they found it. For organisations providing Regulated Services, this will be mandatory.

#### **3.4 There is a robust structure and process for support and supervision appropriate to the post/role.**

For providers of Regulated Services, there will be specific requirements for support and supervision. However, even where not specified, support and supervision is essential to ensure that staff/volunteers feel supported in the work they do, and that the organisation is confident that individuals are carrying out the work to the required standard.

Staff and volunteers should be facilitated to discuss work, support and supervision issues. This will, in turn, assist managers to become aware of and deal with any issues that may prevent the work being carried out effectively, such as resource issues, problematic working relationships between staff/volunteers or difficulties which could highlight the need for additional training.

The overarching benefit of having a good system of support and supervision in place is that the organisation can have confidence in the quality of service being provided.

There are various methods of providing support and supervision from regular one-to-one meetings with individual staff/volunteers, to meetings with a group of staff/volunteers who are engaged in the same type of work. There are advantages and disadvantages to each type of method used: for example, one-to-one meetings on a regular basis for each staff member/volunteer can put demands on time and, in certain circumstances, ratios. On the other hand, group sessions which may appear more efficient, may inhibit staff/volunteers raising concerns they have in front of colleagues and may not be a suitable environment to address certain individual needs.

If using group sessions, it is important to have separate meetings with individual members of staff and volunteers, particularly if they have different roles or undertake different kinds of work.

Whatever the method used, it is useful for the benefit of all parties concerned to have an agenda or checklist of what is to be discussed and a brief written note of the discussion, including actions agreed, who will take them forward and a timetable for completion.

#### **3.5 There is an annual appraisal for staff and review for volunteers.**

An annual appraisal (staff) or annual review (volunteers), to assess and give feedback to individuals on their general performance, is important so that they can be given recognition for the good work they are doing and helped to develop their skills further.

### **See Resource 3.3 – Support/Supervision/Appraisal Checklist**

## Section 3

### **3.6 Comprehensive, written records are kept of: training completed; support and supervision; and annual appraisals.**

It is best practice (and will be a requirement for Regulated Services and Professional Bodies) for written records to be kept of all training completed by staff and volunteers, support and supervision sessions and of annual appraisals.

#### **And finally...**

While the above procedures should apply to both staff and volunteers, it is worth ensuring that everyone in the organisation is clear about the different roles and responsibilities of each.

#### **See Resource 3.4 – Employees and Volunteers - Definitions**

## Resource 3.1 Sample Induction Checklist

What	Who	Date
<b>About the Organisation</b> <ul style="list-style-type: none"> <li>• aims, philosophy and ethos</li> <li>• people we work/volunteer with</li> <li>• work/volunteering we do</li> <li>• limitations of the organisation</li> <li>• structure: departments/teams</li> <li>• management</li> </ul>		
<b>The Building</b> <ul style="list-style-type: none"> <li>• toilets, cloakrooms, parking, etc.</li> <li>• where to get tea/coffee/lunch</li> <li>• health and safety rules</li> </ul>		
<b>The Job/Role</b> <ul style="list-style-type: none"> <li>• worker's/volunteer's area of responsibility</li> <li>• line management</li> <li>• days/hours of work/volunteering and breaks</li> <li>• relevant organisational policies and procedures, including the safeguarding policy</li> <li>• code of behaviour</li> <li>• other policies e.g. confidentiality policy</li> </ul>		
<b>The Support System</b> <ul style="list-style-type: none"> <li>• who will supervise worker/volunteer, where and when to find them</li> <li>• support available</li> <li>• supervision/support meetings</li> <li>• resources, facilities, equipment,</li> <li>• training</li> <li>• complaints procedure</li> </ul>		
<b>Fellow Workers/Volunteers</b> <ul style="list-style-type: none"> <li>• who and what they do</li> <li>• team meetings</li> <li>• working/volunteering with others</li> </ul>		
<b>Other Information</b> <ul style="list-style-type: none"> <li>• settling in – probationary/trial period</li> <li>• claiming expenses</li> <li>• key stakeholders and their roles</li> </ul>		
<p><b>Employee/Volunteer:</b> I confirm that I have completed all items in the induction checklist and, where indicated, read and understood policies and procedures.</p> <p>Signature _____ Date _____</p> <p><b>Line Manager:</b> I confirm that all items in the induction checklist have been completed by (name) either with me, or a member of (organisation) authorised by me.</p> <p>Signature _____ Date _____</p>		

## Section 3

### Resource 3.2 Sample knowledge set of key learning outcomes when training staff/volunteers on safeguarding vulnerable adults

- 1. Roles and boundaries**
  - 1.1** Understand the role, responsibilities and boundaries of the worker with regard to safeguarding individuals from danger, harm and abuse.
  - 1.2** Understand the role, responsibilities and boundaries of the worker with regard to recognising potential and actual danger, harm and abuse.
  - 1.3** Understand the role, responsibilities and boundaries of others with regard to safeguarding individuals from danger, harm and abuse.
  - 1.4** Understand the sources of support for the worker following disclosure or discovery of abuse.
  
- 2. Danger, harm and abuse**
  - 2.1** Understand the different types of abuse/harm.
  - 2.2** Understand that anyone may be at risk of abuse.
  - 2.3** Understand the importance of recognising the indicators of abuse/harm.
  - 2.4** Understand the factors that may lead an individual to harm or abuse.
  - 2.5** Understand the effects of abuse on individuals.
  
- 3. Social norms, values and perceptions**
  - 3.1** Understand the values, social norms and cultural context of people who use the organisation's services and of staff/volunteers; and how actions may be perceived as abusive or protective.
  - 3.2** Understand that, regardless of perceptions, an objective and professional response is required in situations of potential and actual danger, harm and abuse.
  
- 4. Legislation and guidance in relation to the safeguarding of vulnerable adults**
  - 4.1** Be aware of the legislation, regulations and guidance related to the safeguarding of vulnerable adults from danger, harm and abuse.
  - 4.2** Understand the organisation's policies and procedures related to safeguarding vulnerable adults.
  
- 5. Reporting procedures**
  - 5.1** Understand and apply the procedures for recording and reporting concerns about vulnerable adults.
  - 5.2** Understand and apply the principle of confidentiality in relation to safeguarding vulnerable adults, particularly in relation to reporting of concerns.

## Resource 3.3 Support/Supervision/Appraisal Checklist

### 1. Generally:

How do you feel your work is going?

- What's going well?
- What's not been going so well? Why? What would help?
- Is there anything that has happened which you are unsure about? Are there particular situations that you would like to talk through?

### 2. Workload:

What is your workload like? e.g. is it too much, too little or about right?

### 3. Objectives/Actions:

Let's review the objectives we set last time which we need to review.

Last meeting you raised issues of... let's talk about...

### 4. Relationships:

How are you getting on with the rest of the team – staff/volunteers? People who use our services, their carers, family and advocates?

### 5. Personal Development:

Are there things you would like to learn more about/undertake further training on?

### 6. Ideas for Improvement:

Do you have any ideas of how the organisation could improve how it provides its services or its conditions for staff/volunteers?

### 7. Developments to job/role:

Are there any particular projects/new areas of work you would like to explore?

### 8. Objectives/Actions:

Are there any actions that we should set ourselves between now and next time we meet? Is there any particular issue that you would like me to bring to the team/management?

### 9. Safeguarding Vulnerable Adults

Are there any issues in relation to safeguarding vulnerable adults that you would like to raise that we have not discussed.

## Section 3

### Resource 3.4 Employees and Volunteers - Definitions

There are distinct differences between the terms 'volunteer' and 'employee' (or 'paid worker').

Volunteering is defined as *'the commitment of time and energy for the benefit of society and the community, the environment or individuals outside one's immediate family. It is undertaken freely and by choice, without concern for financial gain'*.<sup>9</sup>

Policies and procedures in place to effectively manage volunteers will reflect the voluntary nature of the relationship between the volunteer and the organisation. The only payment received by volunteers will be reimbursement of out of pocket expenses.

Employees will have a contract of employment. This is not just a piece of paper but a relationship between an individual and an organisation where:

- The individual receives remuneration (payment) or consideration (something else of material value) in return for work or services;
- The employer has an obligation to provide work and the individual has an obligation to do the work;
- The work is controlled by the person who is paying;
- The relationship between the parties is consistent with a contract of employment i.e. documentation, management procedures etc.

It is important that these differences are maintained.

More information about the effective involvement of volunteers can be found in *As Good As They Give* (Volunteer Now 2001) available from - [www.volunteering-ni.org](http://www.volunteering-ni.org)

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<sup>9</sup> The compact between Government and the Voluntary and Community Sector in Northern Ireland, 1998

# Section 4



**The organisation has clearly defined procedures for raising awareness of, responding to, recording and reporting concerns about actual or suspected incidents of abuse.**



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### Standard 4

**The organisation has clearly defined procedures for raising awareness of, responding to, recording and reporting concerns about actual or suspected incidents of abuse.**

#### Criteria:

1. All staff/volunteers are aware of what is meant by vulnerability in adulthood, adult abuse, where abuse can occur and who can abuse.
2. There is a Nominated Manager who has responsibility for dealing with concerns about actual or suspected adult abuse, which come to light within the organisation.
3. There is a written procedure for staff/volunteers for responding to, recording and reporting concerns about actual or suspected adult abuse to the organisation's Nominated Manager.
4. There is a procedure for the Nominated Manager to report concerns about actual or suspected adult abuse to the appropriate authorities.
5. There is a procedure for reporting and responding to allegations made against staff and volunteers.
6. There is a system to communicate the reporting procedure to staff/volunteers to ensure they are familiar with it.
7. There is a whistleblowing policy and procedure.

#### 4.1 All staff/volunteers are aware of what is meant by vulnerability in adulthood, adult abuse, where abuse can occur and who can abuse.

Everyone is entitled to have their civil and human rights upheld and to live a life free from abuse and neglect.

##### What can contribute to vulnerability in adulthood?

An adult may be vulnerable to abuse because s/he has a mental health problem, a disability, a sensory impairment, is old or frail, has some form of illness or because of his or her living circumstances, for example, living alone or in isolation or in a residential care home, nursing home or other institutional setting (See Section 5.1).

Staff and volunteers need to be aware of circumstances that may leave an adult vulnerable to abuse and be able to recognise the possible signs of abuse. They should be alert to the demeanour and behaviour of vulnerable adults and those around them and changes that may indicate that something is wrong.

##### What is abuse?

Abuse is a violation of an individual's human and civil rights by any other person or persons. Many incidents of abuse are criminal acts. Abuse is defined as:

*'The physical, psychological, emotional, financial or sexual maltreatment or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship'.<sup>10</sup>*

Abuse can be either deliberate or the result of ignorance, or lack of training, knowledge or understanding. Often if a person is being abused in one way, they are also being abused in other ways. Abuse can take many forms including the following:

##### Physical abuse

- *Including* - hitting, slapping, pushing, burning, giving a person medicine that may harm them, restraining or disciplining a person in an inappropriate way.
- *Possible signs* - fractures, bruising, burns, pain, marks, not wanting to be touched.

##### Psychological abuse

- *Including* - emotional abuse, verbal abuse, humiliation, bullying and the use of threats.
- *Possible signs* - being withdrawn, too eager to do everything they are asked, showing compulsive behaviour, not being able to do things they used to, not being able to concentrate or focus.

##### Financial or material abuse

- *Including* - misusing or stealing the person's property, possessions or benefits, cheating them, using them for financial gain, putting pressure on them about wills, property, inheritance or financial transactions.
- *Possible signs* - having unusual difficulty with finances, not having enough money, being too protective of money and things they own, not paying bills, not having normal home comforts.

<sup>10</sup> From Guidance on Abuse of Vulnerable Adults (Management Executive, Department of Health and Social Services, 1996).

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### Sexual abuse

- *Including* - direct or indirect sexual activity where the vulnerable adult cannot or does not consent to it.
- *Possible signs* - physical symptoms including genital itching or soreness or having a sexually transmitted disease, using bad language, not wanting to be touched, behaving in a sexually inappropriate way, changes in appearance.

### Neglect or acts of omission

- *Including* - withdrawing or not giving the help that a vulnerable adult needs, so causing them to suffer.
- *Possible signs* - having pain or discomfort, being very hungry, thirsty or untidy, failing health, changes in behaviour.

### Discriminatory abuse

- *Including* - the abuse of a person because of their ethnic origin, religion, language, age, sexuality, gender or disability.
- *Possible signs* - the person not receiving the care services they require, their carer being overly critical or making insulting remarks about the person, the person being made to dress differently from how they wish.

### Institutional abuse

This can happen when an organisation where the person is living or receiving care from fails to ensure that the necessary processes and systems are in place to safeguard vulnerable adults and maintain good standards of care and service.

- *Including* - lack of training of staff and volunteers, lack of or poor quality supervision and management, poor record keeping and liaison with other agencies, low staff morale and high staff turnover.
- *Possible signs* - vulnerable adult has no personal clothing or possessions, there is no care plan for him/her, s/he is often admitted to hospital, or there are instances of staff/volunteers having treated him/her badly or unsatisfactorily or acting in a way that causes harm; poor staff morale, high staff turnover and lack of clear lines of accountability and consistency of management.

Sometimes there may be concerns about a vulnerable adult's well-being, which are not dealt with under vulnerable adult protection procedures. Where such concerns arise, they should be reported to the local HSC Trust, as the person concerned may benefit from assessment and intervention. A record of a referral of this nature to a HSC Trust should be maintained.

Relevant contact numbers for each of the HSC Trusts can be accessed through: [www.hscni.net](http://www.hscni.net)

### Where might abuse occur?

Abuse can happen anywhere:

- In someone's own home;
- At a carer's home;
- Within day care, residential care, nursing care or other institutional settings;
- At work or in educational settings;
- In rented accommodation or commercial premises;
- In public places.

## Who can abuse?

An abuser can be anyone who has contact with the vulnerable person - it could be a partner, spouse, child, relative, friend, informal carer, a healthcare, social care or other worker, a peer or, less commonly, a stranger.

### Domestic/familial abuse

- The abuse of a vulnerable adult by a family member such as a partner, son, daughter, sibling.

### Professional abuse

- The misuse of power and abuse of trust by professionals, the failure of professionals to act on suspected abuse/crimes, poor care practice or neglect in services, resource shortfalls or service pressures that lead to service failure and culpability as a result of poor management systems. Possible signs of professional abuse include: entering into inappropriate relationships with a vulnerable adult; failure to refer disclosure of abuse; poor, ill-informed or outmoded care practice; failure to support a vulnerable adult to access health care/treatment; denying a vulnerable adult access to professional support and services such as advocacy; inappropriate responses to challenging behaviours; failure to whistleblow on issues when internal procedures to highlight issues are exhausted.

### Peer abuse

- The abuse of one vulnerable adult by another vulnerable adult within a care setting. It can occur in group or communal settings, such as day care centres, clubs, residential care homes, nursing homes or other institutional settings.

### Stranger abuse

- A vulnerable adult may be abused by someone who they do not know, such as a stranger, a member of the public or a person who deliberately targets vulnerable people.

## 4.2 There is a Nominated Manager who has responsibility for dealing with concerns about actual or suspected adult abuse, which come to light within the organisation.

All organisations working with vulnerable adults should appoint at least one Nominated Manager to be responsible for acting as a source of information and support for staff and volunteers and for dealing with allegations or suspicions of abuse that arise. Everyone in the organisation should know who the Nominated Manager is and how to contact him or her.

This important role should be carried out by someone who, in addition to being in a senior position and having a good knowledge of the organisation, can communicate well internally with staff/volunteers and externally with the appropriate authorities.

Depending on the size of your organisation it may be appropriate to have more than one Nominated Manager and/or Deputy Nominated Manager.

### See Resource 4.1 – Role and Responsibility of a Nominated Manager/Deputy Nominated Manager

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### 4.3 There is a written procedure for staff/volunteers for responding to, recording and reporting concerns about actual or suspected adult abuse to the organisation's Nominated Manager.

When there are concerns or where a disclosure or allegation is made people often feel anxious about passing on the information to anyone else. Concerned individuals may ask themselves, 'What if I'm wrong?' and this may hold them back from taking action. It is important for staff and volunteers to know that they are not responsible for deciding whether or not abuse has occurred; nor are they responsible for conducting an investigation (this is the role of the appropriate authorities). However, they do need to pass on any concerns they have through the organisation's reporting procedures. It is crucial that the staff member/volunteer does not attempt to deal with the situation alone.

#### How can you be alerted to signs of abuse or neglect?

There are a variety of ways that you could be alerted that a vulnerable adult is suffering harm:

- A vulnerable adult may disclose to you;
- Someone else may tell you of their concerns or something that causes you concern;
- A vulnerable adult may show some signs of physical injury for which there does not appear to be a satisfactory or credible explanation;
- A vulnerable adult's demeanour/behaviour may lead you to suspect abuse or neglect;
- The behaviour of a person close to the vulnerable adult makes you feel uncomfortable (this may include another staff member, volunteer, peer or family member); or
- Through general good neighbourliness and social guardianship.

Being alert to potential abuse plays a major role in ensuring that vulnerable adults are safeguarded and it is important that **all** concerns about possible abuse are reported.

#### What if a vulnerable adult discloses abuse?

In cases where a vulnerable adult discloses abuse to a staff member or volunteer, it is important that staff/volunteers know how to react appropriately, according to the following guidelines:

##### Do

- Stay calm;
- Listen and hear;
- Express concern and sympathy about what has happened;
- Reassure the person – tell the person that s/he did the right thing in telling you;
- Let the person know that the information will be taken seriously and give information about what will happen next;
- If urgent medical/police help is required, call the emergency services;
- Ensure the safety of the person;
- Be aware that medical and forensic evidence might be needed;
- Let the person know that they will be kept involved at every stage;

- Record in writing (date and sign your report) and report to the Line Manager/Nominated Manager at the earliest possible time;
- Act without delay.

### Do not

- Stop someone disclosing to you;
- Promise to keep secrets;
- Press the person for more details or make them repeat the story;
- Gossip about the disclosure or pass on the information to anyone who does not have a legitimate need to know;
- Contact the alleged abuser;
- Attempt to investigate yourself;
- Leave details of your concerns on a voicemail or by email;
- Delay.

### Checking out

There may need to be some initial 'checking out' with the vulnerable adult who has disclosed information to you in order to ensure his/her safety, for example, if a staff member/volunteer notices a bruise on a vulnerable adult's arm, it would be appropriate to ask, 'I see you have a bruise on your arm. How did that happen?' However, be careful not to start investigating.

It is important that staff/volunteers understand the clear distinction between 'checking out' and an investigation. Staff/volunteers should **not begin to investigate alleged or suspected abuse** by asking questions that relate to the detail, or circumstances of the alleged abuse, beyond initial listening, expressing concern and checking out.

### Reporting and recording

There may be emergency situations where it is appropriate to contact the police immediately. But whatever the circumstances of the concern, disclosure, allegation or suspicion, it is vital that the staff member/volunteer records the details and reports to their Line Manager or the Nominated Manager in the organisation without delay. It is preferable that all concerns, disclosures, allegations and suspicions are recorded on proformas provided by the organisation. Where a staff member/volunteer reports to a Line Manager, the Line Manager should report to the Nominated Manager immediately.

### See Resource 4.2 – Sample Form for Recording and Reporting Concerns, Disclosures, Allegations and Suspicions of Abuse

An accurate record should be made of the date and time that the member of staff/volunteer became aware of the concerns, the parties who were involved, and any action taken, for example, if first aid was administered. Any questions that staff/volunteers ask in 'checking out' the concerns should also be recorded verbatim.

The record should be clear and factual, since any information you have may be valuable to professionals investigating the incident and may at some time in the future be used as evidence in court. This kind of information should always be kept in a secure place (including electronic filing) and shared only with those who need to know about the concerns, disclosures, allegations or suspicions of abuse.

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It is also good practice for staff/volunteers to record the fact that they made a report, on what date and to whom the report was made.

### Confidentiality

The safeguarding policy should state that information relating to a vulnerable adult or concerns about a vulnerable adult should be confidential and shared on a 'need to know' basis only. Staff and volunteers should be clear that information relating to a concern, disclosure or allegation or suspicion should not be discussed inside or outside the organisation, other than with those, such as the Line Manager or Nominated Manager, who need to know. It is also essential that the organisation has robust systems in place for the maintenance of all records, including records of abuse or suspected abuse (see Section 7).

#### 4.4 There is a procedure for the Nominated Manager to report concerns about actual or suspected adult abuse to the appropriate authorities.

When a Nominated Manager is alerted to concerns about a vulnerable adult, s/he should act promptly and in accordance with the agreed reporting procedure. The procedure should be clear about what the Nominated Manager needs to do, including, the need to:

- Ensure that the vulnerable adult is in no immediate danger and that any medical or police assistance required has been sought;
- Consider whether the concern is a safeguarding issue or not. This may involve some 'checking out' of information provided but being careful not to stray into the realm of investigation.

If it is not considered a safeguarding issue, and it is decided that there should be no referral made to a statutory authority, a record should be made of the concern; details kept on file, including any action taken; the reasons for not referring; and the situation monitored on an ongoing basis. An example that may fall into this category would be an elderly woman who is always very particular about her appearance and clothes, turning up unkempt with items of clothing on inside out for two days in a row. It would be important to record the details of the concern about the woman's appearance and any action taken and the outcome of that action. Action taken may include speaking to the woman and to her carer and recording their responses. The carer's response may indicate that s/he had also noticed the uncharacteristic change in appearance and is equally concerned.

If it is decided that a referral to the HSC Trust will not be made at this point, you should record the decision not to refer and the reasons for not making a referral. In these circumstances, the situation should be monitored so that a referral can be made if the situation deteriorates. Again, your decision to monitor the situation and the outcome of monitoring, e.g. further concerns coming to light, should be recorded.

It is important to remember that while you may not have a safeguarding concern at this point, the local HSC Trust might be able to offer other services.

- Consult with the Designated Officer in the local HSC Trust, where there is any doubt or uncertainty. With reference to the above example, if the carer's response to enquiries about the elderly woman's appearance was hostile, the Nominated Manager should discuss the situation with the Designated Officer in the HSC Trust. Where a discussion has taken place with the HSC Trust Designated Officer, and it is decided that a referral should not be made, this should be

recorded and the situation monitored. Again, the decision to monitor should be recorded. This is important in case further concerns are raised which, when taken together, indicate that the vulnerable adult is being harmed and protective action is required.

- Make a formal referral if the Designated Officer in the HSC Trust considers the concern to be a safeguarding issue. In cases of alleged or suspected criminal abuse, the Designated Officer for the HSC Trust should discuss the case with the relevant Police Liaison Officer in the PSNI, who will help determine whether a crime may have been committed.
- Be available, as required, to the investigation undertaken by the HSC Trust and/or the PSNI (with input from the RQIA, if needed).

**See Resource 4.3 – Reporting Procedure - Flowchart**

**See Resource 4.4 – HSC Trust, PSNI and RQIA Contact Numbers**

### **What information will be required for a referral?**

If a referral is made, as a minimum, the information required will include:

- The name and address of the vulnerable adult and his/her current location;
- The nature of the harm;
- The need for medical attention (if any);
- The reasons for suspicions of abuse;
- Any action already taken;
- Any other information that may be useful to an investigation e.g. information related to the alleged perpetrator and his/her location and whether or not the vulnerable adult is aware of/has agreed to the referral.

All referrals should be made to the appropriate HSC Trust Designated Officer. The contact may be made by telephone in the first instance, but should be confirmed in writing under confidential cover within two working days.

**See Resource 4.5 – Sample Form for Nominated Managers to Report Concerns to the HSC Trust**

Outside normal office hours the referral should be passed to the Out-of-Hours Social Work Service and followed up in writing by the Nominated Manager to the HSC Trust Designated Officer within two working days. You should expect to receive an acknowledgement from the HSC Trust within two working days of the referral. The first priority should always be to ensure the immediate safety and protection of the vulnerable adult. In life threatening situations, such as severe physical abuse, contact emergency services immediately.

## **4.5 There is a procedure for reporting and responding to allegations made against staff and volunteers.**

An allegation against a member of staff or a volunteer is one of the most difficult situations for an organisation to deal with, as the individual who is the subject of the allegation may be a close



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colleague or friend. Nevertheless, the response from the organisation to allegations of abuse must be at all times consistent, regardless of relationships.

When responding to an allegation made against a member of staff or volunteer, an organisation has a dual responsibility; firstly, to the vulnerable adult, and, secondly, to the staff member/volunteer. Organisations should have internal procedures for dealing with allegations against a staff member/volunteer which, in the case of a concern about a vulnerable adult, should run parallel to the process for reporting a concern about a vulnerable adult (see Section 4.4).

### See Resource 4.6 – Handling an Allegation of Abuse against a Staff Member/Volunteer – Flowchart

Initially, all details of the incident should be recorded fully by the Nominated Manager who will pass it on (depending on how the organisation is constituted) to the Line Manager of the individual against whom the allegation has been made or the Head of the organisation. The individual's Line Manager/Head of the organisation should take the actions outlined below. It is possible that the actions outlined will occur virtually simultaneously and not necessarily sequentially.

- Through your organisation's Nominated Manager, consult with the HSC Trust and/or PSNI to ensure that any subsequent action taken by you does not prejudice the HSC Trust or PSNI investigation;
- Following the above consultation, inform the staff member/volunteer that an allegation has been made against him/her and provide them with an opportunity to respond to the allegation. His/her response should be recorded fully;
- Through your organisation's Nominated Manager, refer to the Designated Officer in the HSC Trust, who will liaise with the Police Liaison Officer in the PSNI to agree the most appropriate way forward.
- Take protective measures, which may include suspending the staff member/volunteer or moving him or her to alternative duties. It should be noted that suspension is a neutral act to allow the investigation to proceed and to remove the employee/volunteer from the possibility of any further allegation. Where suspension is considered necessary, it should be dealt with as quickly and sensitively as possible.

All actions taken should be in accordance with your organisation's disciplinary procedure, and have due regard to guidance from the HSC Trust or PSNI so as not to prejudice any HSC Trust or PSNI investigation. It is recommended that the Nominated Manager is not the person who carries out the disciplinary investigation.

### Possible Outcomes of investigation

As a result of the investigation, the allegation may or may not be substantiated.

There are 4 possible investigation outcomes as outlined below:

- **Allegation of harm/risk of harm substantiated – individual removed from regulated activity**

The investigation finds that the allegation is substantiated, that is harm or risk of harm to a vulnerable adult has occurred and the individual is removed from regulated activity. Under these circumstances the organisation will be under a statutory duty to refer to the ISA under the SVG NI Order 2007. It should be at the point that a determination of harm/risk of harm is made and a decision taken to remove an individual from regulated activity that the duty to refer to the ISA is triggered; this may happen at any stage during the disciplinary process and not

necessarily when the process concludes. If the staff member/volunteer resigns or retires at any point during the investigation process, the investigation should nevertheless be concluded and a referral should be made to the ISA if the investigation concludes that harm or risk of harm to a vulnerable adult has occurred. If the individual is registered with a Professional Regulatory Body, the organisation should also make a referral to that body. Further information on the ISA referral process, as well as what is meant by harm can be found in the ISA Referral Guidance.<sup>11</sup>

- **Allegation of harm/risk of harm substantiated - individual reinstated to regulated activity**

The investigation finds that the allegation is substantiated but the circumstances of the case are such that the individual can be reinstated to the post/role subject to appropriate disciplinary sanctions, training/retraining being undertaken and support and supervision arrangements being put in place. The relevant professional body may also need to be informed. Despite the finding that harm/risk of harm has occurred, the decision to return the individual to the post/role means that a referral to the ISA is not required.

- **Allegation of harm/risk of harm unsubstantiated - ongoing concerns**

The investigation finds that the allegation is unsubstantiated, that is the individual has not harmed or placed at risk of harm a vulnerable adult. However, the organisation has ongoing concerns about the conduct of a staff member/volunteer. The organisation may conclude that the individual can be reinstated with additional support, supervision and training/retraining. The relevant Professional Regulatory Body may also need to be informed.

- **Allegation of harm/risk of harm unsubstantiated - no ongoing concerns**

The investigation finds that the allegation is unsubstantiated, that is, the individual has not harmed or placed at risk of harm a vulnerable adult. The staff member/volunteer may be reinstated and provided with support, training and supervision if necessary.

Allegations against members of staff or volunteers can be traumatic and unsettling for any organisation. For this reason, staff and volunteers should have a clear understanding of how allegations will be handled and expect the organisation's disciplinary procedure to be consistently implemented. If, for example, the organisation's policy is to suspend without prejudice when an allegation of abuse or harm is made, all members of staff and volunteers should be aware of the policy. There is an onus on organisations to ensure that the investigation is handled sensitively from initiation to conclusion and to manage any anxieties expressed or demonstrated by any vulnerable adult, carer, family member, advocate or any other member of staff or volunteer.

#### **4.6 There is a system to communicate the reporting procedure to staff/volunteers to ensure they are familiar with it.**

All staff and volunteers should be made aware of the procedure for reporting concerns and an outline of the process if there is an allegation against them. This should be covered at induction stage and through ongoing adult safeguarding training. All staff and volunteers should know the name of and contact details for the Nominated Manager.

#### **What if a staff member's/volunteer's concerns are not taken seriously?**

If a staff member/volunteer raises concerns but the Line Manager/Nominated Manager is reluctant to pass them on, the staff member/volunteer should contact the Head of the organisation. Where this fails, the staff member or volunteer should contact the local HSC Trust's

<sup>11</sup> ISA Referral Guidance available from [www.isa.gov.org.uk](http://www.isa.gov.org.uk)

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Designated Officer with responsibility for safeguarding adults, the PSNI or RQIA if s/he works in a Regulated Service. Contact details should be in the Safeguarding Policy.

### See Resource 4.4 – HSC Trust, PSNI and RQIA Contact Numbers

#### 4.7 There is a whistleblowing policy and procedure.

Whistleblowing occurs when a staff member/volunteer raises a concern about misconduct, illegal or underhand practices by individuals and/or an organisation; or about the way care and support is being provided, such as practices that cause harm or the risk of harm to others or are abusive, discriminatory or exploitative. This will include situations where a staff member's/volunteer's concerns are not acted upon by the Line Manager, the Nominated Manager or Head of the organisation (see Section 4.6).

Your organisation should have a whistle-blowing policy, which makes it clear that:

- The organisation takes poor or malpractice seriously, giving examples of the types of concerns to be raised, to ensure that a whistle-blowing concern is clearly distinguished from a grievance;
- Staff or volunteers have the option to raise concerns outside of line management structures;
- Staff or volunteers are enabled to access confidential advice from an independent source;
- The organisation will, where possible, respect the confidentiality of a member of staff raising a concern;
- When and how concerns may be raised outside the organisation (e.g. with a regulator);
- It is a disciplinary matter both to victimise a bona fide whistleblower and for someone to maliciously make a false allegation.

You should ensure that staff/volunteers are aware of and have confidence in your whistleblowing procedure and regularly review how the procedure works in practice.

## Resource 4.1 Role and Responsibility of a Nominated Manager/Deputy Nominated Manager

### General

Every organisation should nominate a person or persons to be responsible for dealing with any safeguarding concerns about vulnerable adults.

The organisation's safeguarding vulnerable adult policy and procedures should include the name of this person, his/her role and responsibilities and how s/he can be contacted.

The person nominated should ensure that s/he is knowledgeable about vulnerable adult safeguarding issues and that s/he undertakes any training, considered necessary, to keep up to date with developments in safeguarding.

### Role

The role of the Nominated Manager is to:

- Establish contact with the Designated Officer in the HSC Trust and the Police Liaison Officer in the PSNI responsible for vulnerable adult protection in the organisation's catchment area;
- Provide information and advice on safeguarding vulnerable adults within the organisation;
- Ensure that the organisation's safeguarding vulnerable adult policy and procedures are followed and particularly to inform the Designated Officer within the appropriate HSC Trust or PSNI of safeguarding concerns about individual adults;
- Ensure that appropriate information is available at the time of referral and that the referral is confirmed in writing, under confidential cover;
- Liaise with the HSC Trust, PSNI and other agencies, as appropriate;
- Keep relevant people within the organisation, particularly the Head of the organisation, informed about any action taken and any further action required;
- Ensure that an individual case record is maintained of concerns about abuse and the action taken by the organisation, the liaison with other agencies and the outcome;
- Advise the organisation of safeguarding vulnerable adult training needs.

### Responsibility

The Nominated Manager is responsible for acting as a source of advice on vulnerable adult safeguarding matters, for co-ordinating action within the organisation and for liaising with the HSC Trust, PSNI and other agencies, as appropriate, about suspected or actual cases of vulnerable adult abuse.

**Section 4**

**Resource 4.2 Sample Form for Recording and Reporting Concerns, Disclosures and Allegations or Suspicions of Abuse.**

**Vulnerable Adult Abuse Report Form**

**Please answer all relevant questions as fully as you can.**

Work location
Name of Vulnerable Adult
Age/Date of Birth
Gender
Names of carers (if known)
Home address (if known)
<b>Please complete those sections below that are relevant.</b>
<b>1. Disclosure by a vulnerable adult</b>
When was the disclosure made (dates and times)?
Who did the vulnerable adult make the disclosure to?
What did the vulnerable adult actually say?

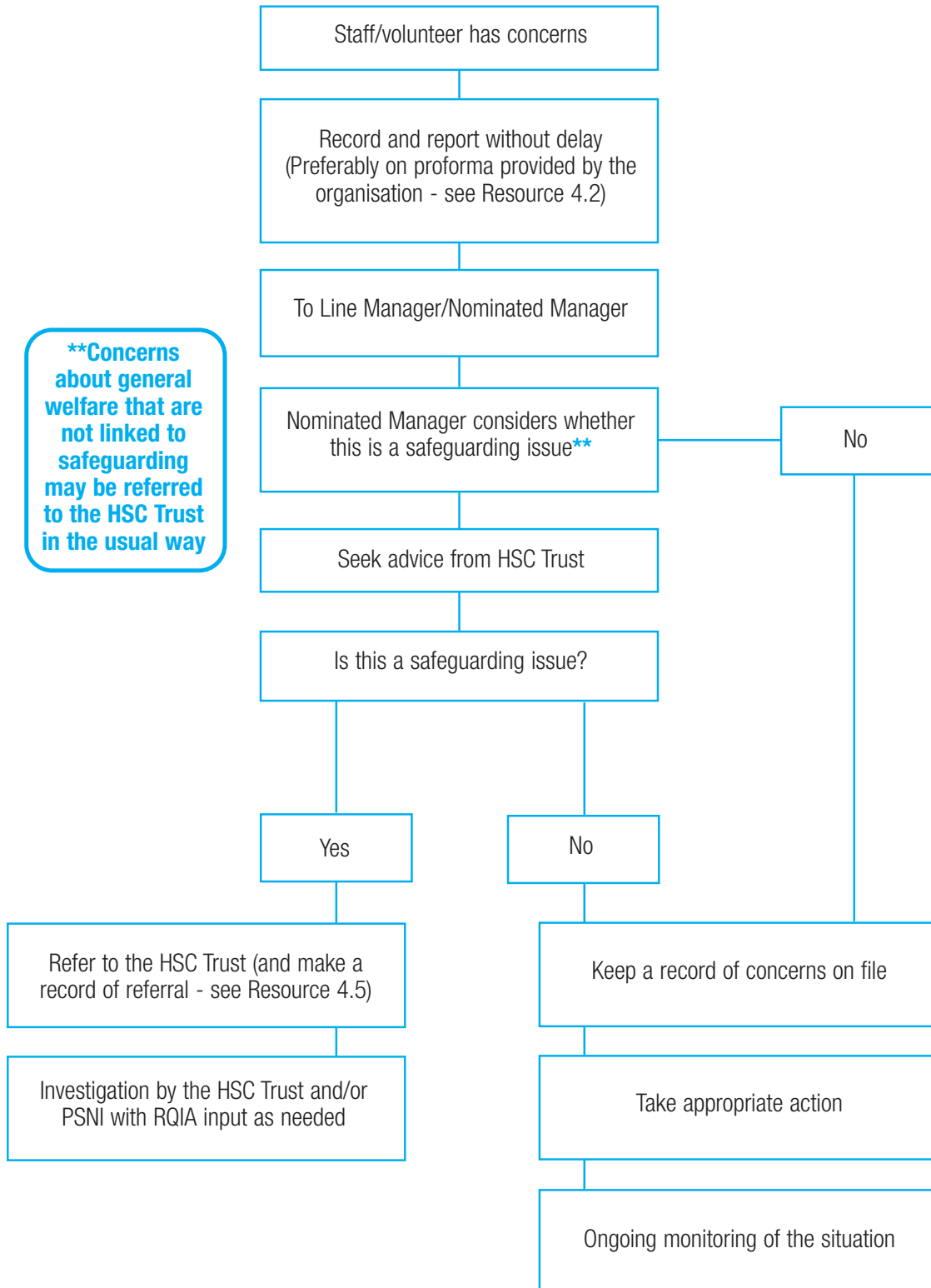
<b>2. Indicators</b>
Describe any signs or indicators of abuse (with times and dates)
Has the vulnerable adult alleged that any particular person is the abuser (if so, please record details and the relationship, if any, to the vulnerable adult below)
<b>3. Concerns expressed by another person about a vulnerable adult</b>
Record the concerns that were passed to you (with dates and times) and if possible ask the person who expressed the concerns to confirm that the details as written are correct
<b>4. Details of any immediate action taken, e.g. first aid, etc</b>

**Section 4**

<b>5. Has the vulnerable adult expressed any reservations about you talking to the Line Manager or Nominated Manager about the matter?</b>	
<b>6. Does the vulnerable adult have any particular needs, e.g. communication, etc?</b>	
<b>Signatures</b>	
<i>To be signed by the person reporting the concern</i>	
Name	
Job title	
Signed	
Date	
<i>Date received and actioned by Line Manager</i>	
Name	
Signed	
Date	
<i>Date received and actioned by Nominated Manager</i>	
Name	
Signed	
Date	
Action taken by Line Manager/Nominated Manager	
Signed	Date

**Resource 4.3 Reporting Procedure – Flow Chart**

Every organisation should have procedures in place for dealing with concerns raised by staff and volunteers and for reporting those concerns to the local HSC Trust, PSNI or RQIA where appropriate. It is preferable that proformas are used for reporting purposes.





## Section 4

### Resource 4.4 HSC Trust, PSNI and RQIA Contact Numbers

#### HSC Trusts

	<b>Normal working hours (9am to 5pm)</b>	<b>Out of hours*</b>
Belfast	(028) 9056 5707	(028) 9056 5444
Northern	(028) 2563 5558	(028) 9446 8833
South Eastern	(028) 9266 5181 extension 4544	(028) 9056 5444
Southern	(028) 3083 2650	(028) 3083 5000
Western	(028) 7131 4090	(028) 7134 5171

**\*NOTE:** Out of hours means 5pm to 9am; weekends; and bank or other public holidays.

#### PSNI

Emergency	999
Non Emergency	0845 600 8000
General Enquiries	0845 600 8000

#### RQIA

	<b>Normal working hours (9am to 5pm)</b>
Belfast	(028) 9051 7500
Omagh	(028) 8224 5828

## Resource 4.5 Form for Nominated Managers to Report Concerns to the HSC Trust

### CONFIDENTIAL

This form should be completed by the Nominated Manager and the information provided to the local HSC Trust **immediately** when there is a concern of abuse or suspected abuse of a vulnerable adult that has been drawn to your attention. You should provide as much detail as possible but **do not** investigate the abuse/ suspected abuse.

<b>ORGANISATION INFORMATION</b> <i>(this section can be completed in advance)</i>	
Name:	
Address:	
	Postcode:
Tel No:	Email Address:
<b>VULNERABLE ADULT INFORMATION</b>	
<b>FULL NAME:</b>	Known By:
Age or Date of Birth:	
Address:	
	Postcode:
Tel No:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Current Location:
<b>GP NAME:</b>	
Address:	
	Postcode:
Tel No:	
<b>NEXT OF KIN:</b>	
Address:	
	Postcode:
Tel No:	
Is the vulnerable adult aware that the abuse/suspected abuse has been reported: Yes <input type="checkbox"/> No <input type="checkbox"/>	

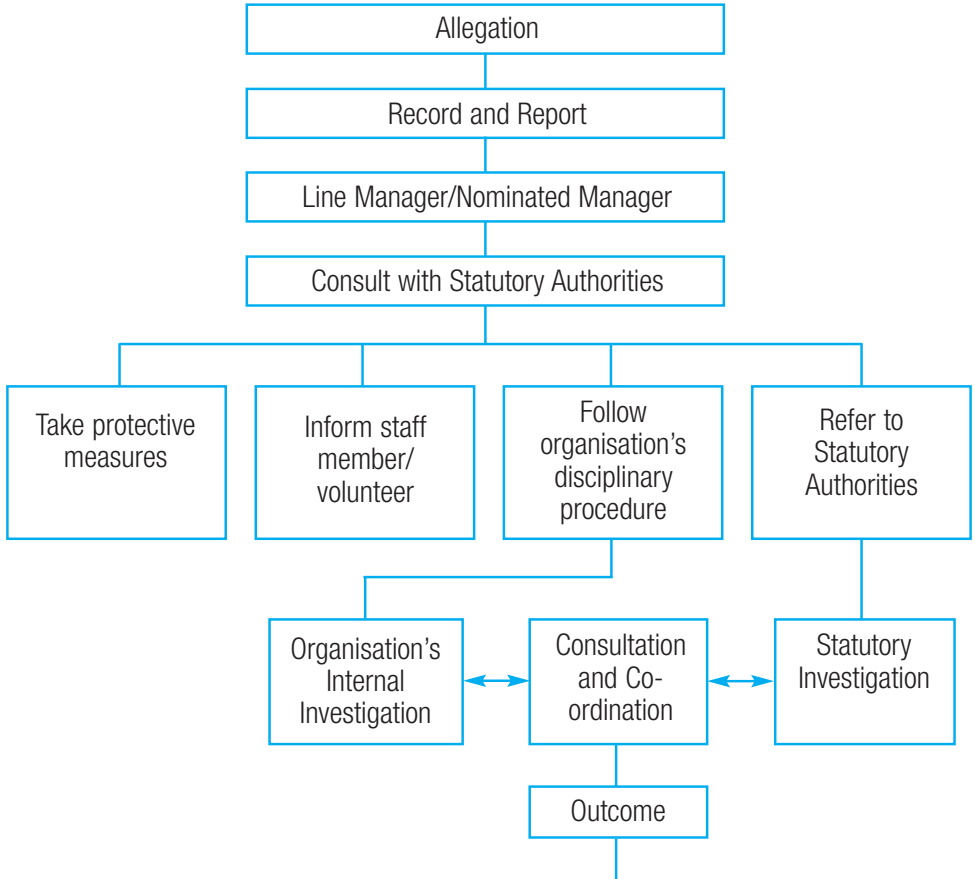
**Section 4**

<b>ABUSE/SUSPECTED ABUSE INFORMATION</b>	
Describe the nature of the harm and the reasons for your suspicions of abuse, providing as much information as possible: <i>(e.g. dates, times, locations)</i>	
Any known previous concerns or evidence of abuse? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details:	
Was medical attention necessary? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details:	
Briefly describe any other action taken:	
Concern reported by:	
Tel No:	
Date Reported:	
Time Reported:	
Does this person wish to remain anonymous? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the vulnerable adult have any particular needs? e.g. communication, disability etc? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details	

<b>ALLEGED PERPETRATOR INFORMATION</b>	
Name:	
Age:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Address/Current Location:	
Relationship to Vulnerable Adult:	
Is the alleged perpetrator aware of the allegation? Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
Is the alleged perpetrator aware that a referral has been made? Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	
<b>REPORTED to the HSC Trust</b>	
Date Reported:	
Time Reported:	
Nominated Manager Signature:	
Date:	

**Section 4**

**Resource 4.6 Handling an Allegation of abuse against a Staff Member/Volunteer – Flow Chart**



1  <b>or</b>	Allegation of harm/risk of harm substantiated - individual removed from regulated activity.	Refer the individual to the ISA and if relevant, inform appropriate professional body.
2  <b>or</b>	Allegation of harm/risk of harm substantiated - individual reinstated to regulated activity.	Appropriate disciplinary sanction should be applied, training/retraining undertaken, appropriate support and supervision provided. If relevant, inform appropriate professional body.
3  <b>or</b>	Allegation of harm/risk of harm unsubstantiated - ongoing concerns, e.g. practice concerns.	Staff member should be offered additional support, training/retraining and supervision if necessary. If relevant, inform appropriate professional body.
4	Allegation of harm/risk of harm unsubstantiated - no ongoing concerns.	Staff member should be offered additional support, training/retraining and supervision if necessary.

# Section 5



**The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding vulnerable adults.**

## Section 5

### Standard 5

**The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding vulnerable adults.**

#### Criteria:

1. A risk assessment is carried out to identify and evaluate risks to vulnerable adults.
2. The identified risks are managed by putting in place risk-reducing measures.
3. All identified risks and risk-reducing measures are recorded and reviewed at least once per year.
4. The organisation should recognise that vulnerable adults have the right to take risks and should provide help and support to enable them to identify and manage potential and actual risks to themselves and others.
5. The organisation has a procedure in place for reporting, recording and reviewing accidents, incidents and near misses, which should in turn inform practice and the risk assessment and management procedure.

## 5.1 A risk assessment is carried out to identify and evaluate risks to vulnerable adults.

Assessing and managing risks to vulnerable adults should be integral to your organisation's risk management strategy. Risks may relate to the working of the organisation; its provision of services; its delivery of individual activities; or its social guardianship responsibility.

### What is risk assessment?

Assessment of risk is the process of examining what could possibly cause harm to vulnerable adults, staff, volunteers or others in the context of the activities and services your organisation provides; in the interactions with and between vulnerable adults; and with the wider community.

Risk of harm can be posed by actions and inactions in many different situations such as:

- intimidation and other threatening behaviours;
- behaviours resulting in injury, neglect, abuse, and exploitation by self or others;
- the use of medication;
- the misuse of drugs or alcohol;
- aggression and violence;
- suicide or self-harm;
- a person's impairment or disability; or
- accidents, for example, whilst out in the community or participating in a social event or activity.

For the individual, the level of risk, that is the likelihood of an event occurring and the impact it might have depends on the nature of the person, their relationships with others, the choices open to them and the circumstances in which they find themselves.

For the organisation, the level of risk will depend on the balance achieved between the right of a vulnerable adult to be safeguarded; the duty of care owed to the vulnerable adults served by the organisation; the duty of care owed by the organisation to its staff/volunteers; the legal duties of statutory bodies and service providers; and the right of vulnerable adults to make informed lifestyle choices and take part in activities.

No endeavour or activity, or indeed interaction, is entirely risk free and even with good planning, it may be impossible to completely eliminate risks from any activity, service or interaction. However, having in place good risk assessment and management practice is essential to reduce the likelihood and impact of identified risks. In some situations, living with a risk can be outweighed by the benefit of having a lifestyle that the individual really wants, values and freely chooses. In such circumstances, risk-taking can be considered to be a positive action. Consequently, as well as considering the dangers associated with risk, the potential benefits of risk-taking have to be considered.



## Section 5

### Why assess and manage risk?

In assessing and managing risks, the aim is to minimise either the likelihood of risk or its potential impacts. In safeguarding terms, the aim of risk assessment and management is to prevent abuse occurring, to reduce the likelihood of it occurring and to minimise the impacts of abuse by responding effectively when it does occur. An organisation should always take time to identify, evaluate and put in place risk-reducing measures.

### Principles of working with risk

A number of important issues need to be considered by staff and volunteers who carry out risk assessments and risk management in relation to vulnerable adults:

- The assessment and management of risk should promote the independence, real choices and social inclusion of vulnerable adults;
- Risks change as circumstances change;
- Risk can be minimised, but not eliminated;
- Information relating to vulnerable adults, activities, relationships and circumstances will sometimes be incomplete and possibly inaccurate;
- Identification of risk carries a duty to do something about it, i.e. risk management;
- Involvement of vulnerable adults, their families, advocates and practitioners from a range of services and organisations helps to improve the quality of risk assessments and decision-making;
- 'Defensible' decisions are those based on clear reasoning;
- Risk-taking can involve everybody working together to achieve positive outcomes;
- Confidentiality is a right, but not an absolute right and may be breached in exceptional circumstances when people are deemed to be at serious risk of harm or it is in the public interest;
- The standards of practice expected of staff/volunteers must be made clear by their team manager/supervisor to give them the confidence to support decisions to take risk;
- Sensitivity should be shown to the experience of people affected by any risks that have been taken and where an event has occurred.

### The risk assessment process

There are a number of risk assessment methodologies available and it is important to use the methodology that is most suited to your organisation's activities, or that is recommended or required by a Regulatory Body.

The risk assessment process involves:

- The identification of risks; and
- Determining the level of risk by evaluating its potential impact and the likelihood of it happening.

## The identification of risks

This involves identifying in advance what risks may be associated with all of the activities of your organisation and the services you provide. Risks may vary for individuals and can depend on the nature and extent of an individual's vulnerability. Identification of risk should involve a balanced approach which looks at what is and what is not an acceptable risk. When identifying risks, there should be a specific focus on safeguarding risks, for example, by identifying the circumstances where abuse or exploitation are more likely to occur.

Risk to vulnerable adults is known to be greater when:

- The vulnerable adult is emotionally or socially isolated;
- A pattern of violence exists or has existed in the past;
- Drugs or alcohol are being misused;
- Relationships are placed under stress.

When care services are provided, abuse is more likely to occur if staff/volunteers are:

- Inadequately trained;
- Poorly supervised;
- Lacking support or working in isolation.

In addition, to the known risk factors, a range of other factors may increase the likelihood of abuse:

- Where an illness causes unpredictable behaviour;
- Where the person is experiencing communication difficulties;
- Where the person concerned demands more than the carer can offer;
- Where the family dynamics undergoes change in circumstances (for example the sudden death of partner, unemployment, divorce);
- Where a carer has been forced to change their lifestyle as a result of becoming a carer;
- Where a carer experiences disturbed nights on a regular basis;
- Where a carer becomes isolated and is offered no relief from a demanding role;
- Where other relationships are unstable or placed under pressure whilst caring;
- Where persistent financial problems exist;
- Where a partner abuses drugs (especially alcohol), is unemployed or underemployed, is poorly educated or has been in a previous, perhaps turbulent, relationship with the victim;
- Where a victim seeks to disclose abuse; get support; or to leave an abusive relationship.

The circumstances and factors listed above are neither exhaustive nor placed in order of priority.

The number of staff/volunteers available is crucial, and, for Regulated Services, the need for an appropriate number of suitably qualified, skilled, competent and experienced staff is a requirement. How and where services and activities are organised can also heighten or lessen the level of risk.

## Section 5


### Determining the level of risks

You need to be able to determine the level of risk (e.g. high, medium or low) associated with the risks identified. The purpose of determining the level of risk is to establish which risks warrant most attention. While an organisation will want to be mindful of all risk, those which have been determined to be 'high' level should be given the greatest and most urgent attention.

The level of risk is a combination of likelihood and impact. For each risk identified, you need to rate the risk according to the likelihood of it happening (e.g. from unlikely to likely) and the seriousness of the impact (e.g. from minor to major) if it were to happen. The matrix below maps 'likelihood' against 'impact' and gives an overall risk level of high, medium or low.

For example, an organisation, which provides services to adults with epilepsy, might assess the level of risk associated with an adult with severe epilepsy having a seizure as high, on the grounds that a seizure is 'likely to occur' and will have a 'major impact' if it does. As a risk-reducing measure, the organisation would want to ensure that it had sufficient numbers of staff available, trained in responding appropriately to seizures.

To take another example, the abuse of a vulnerable adult would in all cases be considered as having a major impact on the adult involved. To reduce the likelihood of the risk of abuse occurring, the organisation will want to put in place a range of safeguarding measures (as set out in the Safeguarding Policy), the aim of which is to reduce the likelihood of abuse.

LIKELIHOOD of the identified risk	Determining the levels of risk		
Likely	Medium	Medium	High
Possible	Low	Medium	High
Unlikely	Low	Medium	High
	Minor	Moderate	Major
	 <b>IMPACT of the identified risk</b>		

Note that the level of risk, assessed as high, medium or low, is a combination of the likelihood of an identified risk occurring and the impact it would have if it did occur. So where a risk is:

- **likely to occur** and of **major impact** the level of risk is **high**;
- **possible** and of **moderate impact** the level of risk is **medium**; and
- **unlikely** and of **minor impact** the level of risk is **low**.

## 5.2 The identified risks are managed by putting in place risk-reducing measures.

### The management of risk

The next step is to look at what can be done to reduce the likelihood and lessen the impact of the identified risks. Risks can be managed in a number of ways. It is the responsibility of a named individual (the risk owner) to ensure that each identified risk is properly managed. Risk ownership is an ongoing process for the lifetime of the identified risk. The risk owner will normally be a senior person within the organisation and s/he will be named in the organisation's risk log/register (see Section 5.3), alongside the risk(s) for which s/he is responsible.

For the organisation, the primary aim of the Safeguarding Policy (see Section 1) is to manage the risk of abuse to vulnerable adults by establishing an organisational culture in which the rights of vulnerable adults are fully respected and by putting in place a range of procedures which support that culture. Establishing a culture, which is mindful of and has a 'zero tolerance' of abuse wherever it occurs and whoever causes it, and putting in place robust procedures are all part of an organisation's risk-reducing armoury. If properly implemented, the Safeguarding Policy has the potential to reduce both the likelihood and impact of abuse by, for example:

- Preventing unsuitable people from joining the organisation through good recruitment and selection practice;
- Making staff and volunteers aware of the indicators of vulnerability and risk and the possible signs of abuse and equipping them to respond quickly to concerns about actual, alleged or suspected abuse;
- Ensuring that staff and volunteers are properly inducted, trained, supported and supervised in their work with vulnerable adults;
- Ensuring that staff and volunteers know what constitutes acceptable behaviours and good practice and that they are supported when they challenge poor practice;
- Promoting a culture of inclusion, transparency and openness throughout the organisation and its services and activities;
- Making staff and volunteers aware of how information about vulnerable adults should be handled; and
- Having in place good overall organisational management and practice supported by a range of organisational policies and procedures.

### Risk management options

For activity/service provision, an identified risk can be managed in a number of ways. It can be avoided, controlled, financed, transferred or accepted.

#### Avoid the risk

If the level of risk cannot be satisfactorily reduced through other means, you may decide not to engage in a particular activity or provide a particular service.

- *Example:* Due to widespread travel disruption there is a high risk of an insufficient number of staff/volunteers being present to safely supervise an activity for vulnerable adults with physical disabilities who require assistance to participate. As the risk of injury is considered too great in such circumstances, the activity is cancelled.

## Section 5

### Control the risk

Controlling risk involves implementing measures to both reduce the likelihood of a harmful event occurring and to minimise the impact of such an occurrence. This is about identifying the good practice policies that need to be adhered to and the staff/volunteer training required to reduce risk and harm.

- *Example:* An organisation which provides activities for an adult with severe epilepsy will ensure that there are suitably trained staff/volunteers present at all times to deal with the situation should the person have a seizure. While the likelihood of a seizure happening may be high, the impact will be reduced by having in place sufficient numbers of staff trained to deal with seizures.

### Finance the risk

It is important to provide resources to meet the liabilities caused by the risks when they are identified.

- *Example:* An organisation which risks losing volunteers because some of them are out of pocket through their volunteering, may decide to allocate a budget to cover volunteer expenses. So while the impact of losing volunteers may be high, the likelihood of it happening will be reduced by financing the risk.

### Transfer the risk

This typically happens when an organisation decides to have a qualified third party carry out a particular activity so that the risk is transferred to him/her.

- *Example:* An organisation does not have adequately qualified staff or volunteers to take a group of physically disabled adults canoeing and commissions qualified instructors to do this.

Risk of financial loss can be mitigated through insurance, indemnity or exemption from liability. However, if an organisation fails to take reasonable steps to prevent/manage risk, then it may still be liable, despite insurance or any form of indemnity or exemption from liability.

### Accept the risk

Tolerate the risk, perhaps because no reasonable action can be taken to mitigate it or the likelihood of the risk occurring and its impact are at an acceptable level. An organisation should only ever accept risks, which they have judged to be very low level, without putting in place some form of risk-reducing measure. All the while, having regard to the positive outcomes for the vulnerable adult that may accrue from positive risk taking ([see Section 5.4](#)).

### 5.3 All identified risks and risk-reducing measures are recorded and reviewed at least once per year.

It is essential that all risks and risk-reducing measures are recorded. Typically this will take the form of a Risk Register. For organisations dealing with vulnerable adults, it would be helpful to have a section of the Risk Register that deals specifically with safeguarding risks. It is also essential that risks and risk-reducing measures are kept under review. It is recommended that a risk review should be carried out at least once per year. Also, a risk review may be necessary at the point an organisation undergoes a process of change, for example, in circumstances where organisations with different cultures or experience merge or an organisation takes on a new activity or service.

### See Resource 5.1 – Sample Risk Register

**5.4 The organisation should recognise that vulnerable adults have the right to take risks and should provide help and support to enable them to identify and manage potential and actual risks to themselves and others.**

It is important that the organisation has a policy of 'positive risk-taking' and avoids becoming totally risk averse. Risk averse cultures can stifle and constrain and could lead to inappropriate restriction to the individual's rights. Life is never risk free. Some degree of risk-taking is an essential part of fostering independence. For instance, if you identify an activity or set of circumstances as potentially risky to a vulnerable adult or group of vulnerable adults, this needs to be offset against the benefits which the individual or group might draw from taking part in that activity. Risk-taking should be pursued in a context of promoting opportunities and safety, not poor practice.

In a culture of positive risk-taking, risk assessment should involve everyone affected – vulnerable adults and carers, advocates, staff and volunteers and, where they are involved, health and social care staff.

**5.5 The organisation has a procedure in place for reporting, recording and reviewing accidents, incidents and near misses, which should in turn inform practice and the risk assessment and management procedure.**

Very often, there are lessons to be learned from accidents, incidents or near misses, which occur within an organisation. As a result, the organisation should have in place a procedure for reporting and recording accidents, incidents and near misses that occur. These may involve vulnerable adults; they can also involve staff members or volunteers. Staff and volunteers should be aware of the reporting and recording procedure.

Accidents, incidents and near misses, particularly those which are recurring, can be indicators of organisational risk, including a risk to safeguarding, which needs to be managed. It is important, therefore that the risk identification exercise makes reference to reported accidents, incidents and near misses and that the learning from these is (a) identified and disseminated to staff and volunteers; and (b) used to inform changes in practice, policy and procedures.

Where the accident, incident or near miss is in some way connected to a safeguarding matter, it should be drawn to the attention of the Nominated Manager for appropriate action.

**See Resource 5.2 – Sample Accident/Incident/Near Miss Record Form**

Section 5

**Resource 5.1 Sample Risk Register**

Identify <b>MAIN RISKS</b> to people, property and/or organisation's work and reputation	Evaluate the seriousness of these risks		Assessed Level of Risk	Risk Owner	How can you manage these risks?	Action Completed (date)	By Whom	Review		
	Likelihood of it happening	Impact of it happening								
A)	Unlikely	Minor	Combination of likelihood and impact  Low Medium High		Stop the Activity			How and when will you review the risks in this area?		
	Possible	Moderate			Reduce the Risk				Finance the Risk	
	Likely	Major			Transfer the Liability					
B)										

## Resource 5.2 Sample Accident/Incident/Near Miss Record Form

### ACCIDENT/INCIDENT/NEAR MISS

*Please circle one of the above*

REPORT FORM Ref No:

Name: <i>(person involved/injured)</i>		Date:	Time:
<i>If more than one person has been involved please use separate forms for each person.</i>			
Status: Vulnerable Adult <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Visitor <input type="checkbox"/> Other <input type="checkbox"/>			
If Other, please specify:			
Details of Accident/Incident/Near Miss: <i>(Please include what happened prior, event details and what was done immediately/by whom?          Please include a drawing if helpful and use extra sheets if necessary).</i>			
Details of injuries or damages and any first aid/medical treatment given:			
Name of Person Reporting:			
Job Title:		Date:	



## Section 5

### Manager Section

Long Term Action Plan: <i>(What action is to be carried out to prevent the Accident/Incident/Near Miss happening again).</i>	
Is a risk assessment (or support plan) review required as a result of this Accident/Incident/Near Miss?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Action to be carried out by: <i>(name)</i>	By Date:
Line Manager Section Reviewed by: <i>(name)</i>	Date:
RIDDOR <sup>12</sup> Report confirmed by: <i>(name)</i>	Date:

<sup>12</sup> The reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), place a legal duty on employers, self-employed people, people in control of premises to report work-related deaths, major injuries or over-three-day injuries, work related diseases and dangerous occurrences (near miss accidents).

# Section 6



**There are clear procedures for receiving comments and suggestions, and for dealing with concerns and complaints about the organisation.**

## Section 6

### Standard 6

**There are clear procedures for receiving comments and suggestions, and for dealing with concerns and complaints about the organisation.**

#### Criteria:

1. The organisation has an ethos of inclusion, transparency and openness which is communicated to vulnerable adults, carers, advocates, family members, staff and volunteers.
2. There are appropriate procedures in place for carers, advocates and vulnerable adults to share concerns they may have or to make complaints about the organisation.
3. Complaints procedures are communicated appropriately to vulnerable adults, carers, advocates, staff and volunteers.

### **6.1 The organisation has an ethos of inclusion, transparency and openness which is communicated to vulnerable adults, carers, advocates, family members, staff and volunteers.**

Having a culture of inclusion, transparency and openness means that an organisation has nothing to hide in terms of its practice, and that it is open to feedback from vulnerable adults, carers, advocates, staff and volunteers with a view to improving how it carries out its activities and delivers its services.

It is important to communicate that your organisation is committed to this principle through having a statement to this effect in your Safeguarding Policy. Such a statement should also be prominently displayed in your premises and in information materials about the organisation.

An organisation, which purports to treat vulnerable adults with dignity and respect and is committed to safeguarding them from harm will encourage and enable them to take an active role in planning and decision-making.

Some ways this can be achieved are through:

- A commitment to a listening environment within the organisation;
- A suggestion box to give everyone an opportunity to make suggestions about how things could be improved;
- A consultative committee of vulnerable adults and staff/volunteers who discuss matters affecting their interests;
- Maintaining a record of matters and suggestions made by vulnerable adults and their representatives and actions taken;
- Involvement of vulnerable adults on interview panels;
- Providing regular feedback on actions taken and developments in the organisation.

It is also important to establish and maintain contact with the carers and advocates of vulnerable adults who are involved in your organisation. Carers and advocates will have a wealth of knowledge about the emotional, physical and cultural needs of vulnerable adults whom they care for or work with.

Involvement of carers and advocates can range from their representation on management committees, to their participation in services or activities provided by the organisation for vulnerable adults. Such involvement will also be an important source of reassurance and support for carers.

Good management should help to ensure that the organisation is operating effectively. Managers can gain valuable insights or learn lessons through the support and supervision processes. In addition, feedback can also be gained from satisfaction surveys that staff and volunteers, carers, advocates and vulnerable adults can complete anonymously.

### **6.2 There are appropriate procedures in place for carers, advocates and vulnerable adults to share concerns they may have or to make complaints about the organisation.**

Where carers or vulnerable adults or their advocates have a concern or complaint about some aspect of the organisation, they should have access to the organisation's complaints procedure.

## Section 6

In a complaints procedure the following issues should be addressed:

- Who is the first point of contact for the complaint? There should be a named alternative in case the first point of contact is unavailable (e.g. on holiday) or is the subject of the complaint;
- If the complaint cannot be resolved at the first stage, how will it be dealt with subsequently? It is usual, but not always necessary, to have a number of stages in a complaints procedure. The aim is to provide a clear and fair process;
- State clearly where the final decision lies, and whether there is any option to appeal against it;
- Specify realistic time limits for each stage: complaints should be dealt with promptly.

Everyone involved, the complainant and the subject(s) of the complaint, should be given the opportunity to represent their side of the case. In the case of a complaint from a vulnerable adult, representation might include input from a carer or an advocate. In the case of a complaint made by a carer, representation might include input from a friend or family member. If the complaint is about a member of staff, volunteer or family member or carer acting inappropriately, the person dealing with the complaint should be very clear about:

- The particular incident of concern;
- Any previous incidents;
- Any remedial action to be taken e.g. an apology;
- Any new behaviour expected;
- What will happen if the agreed arrangements are not adhered to.

Records of discussions and information shared at each stage of the complaints procedure should be made clearly and accurately. All information relating to the complaint should be kept confidential and stored in a secure location. Organisations which provide Regulated Services will need to ensure that their complaints procedure complies with the appropriate regulatory requirement.

### See Appendix 2 – Standards

#### What about serious incidents?

If there is a complaint in relation to a particularly serious incident, for example, where abuse or exploitation is suspected, then the reporting procedure takes precedence over the complaints procedure (see Section 4).

### 6.3 Complaints procedures are communicated appropriately to vulnerable adults, carers, advocates, staff and volunteers.

As well as the complaints procedure being outlined in the safeguarding policy, it should be displayed on the premises and in material relating to the organisation. If necessary, it should be provided in alternative formats, and one-to-one explanations should be provided if required.

While volunteers should use the complaints procedure, members of staff should have access to the organisation's grievance procedure. The organisation should also have a whistleblowing policy for staff and volunteers where there are concerns about malpractice in the organisation (see Section 4.7).

# Section 7



**The organisation has a clear policy on the management of records, confidentiality and sharing of information.**

## Section 7

### Standard 7

**The organisation has a clear policy on the management of records, confidentiality and sharing of information.**

#### Criteria:

1. The policy is based on an expectation of confidentiality in the recording, use and management of personal information.
2. The policy informs staff and volunteers what information needs to be recorded.
3. The policy informs staff and volunteers how written records should be secured, stored and eventually disposed of.
4. The policy outlines what and how information is shared with relevant people within and outside of the organisation.
5. Vulnerable adults involved with the organisation should have access to information held about them.

## 7.1 The policy is based on an expectation of confidentiality in the recording, use and management of personal information.

Your organisation should have a clear statement about confidentiality and how this is to be respected in the context of safeguarding work. It is important that staff and volunteers in the organisation know that personal and sensitive details about the lives of vulnerable adults with whom they work or who are in their care and their families should not be the subject of gossip, or passed on to others without good cause or reason. Care should be taken to ensure that when cases do have to be discussed with colleagues, the details cannot be overheard by others. Information of a confidential nature should only be communicated on a need-to-know basis and, in most circumstances, with the consent of the vulnerable adult.

The DHSSPS Code of Practice on Protecting the Confidentiality of the Service User Information (2009) provides practical guidance to assist decision-making about the disclosure of personal information and the legal context in Northern Ireland in relation to confidentiality and disclosure.

As stated in the DHSSPS Code:

'...the obligation to protect confidentiality can be expressed in terms of three core ethical principles which underpin the law:

- individuals have a fundamental right to the confidentiality and privacy of information related to their health and social care;
- individuals have a right to control access to and the disclosure of their own health and social care information by giving, withholding or withdrawing consent;
- for any disclosure of confidential information, health and social care staff should have regard to its necessity, proportionality and any risks attached to it.'

However, staff and volunteers should be clear that in circumstances where they have concerns about an individual's safety and welfare or the safety of others, they should pass on information that they may have been told in confidence. The information should be passed on to the Line Manager or the Nominated Manager, as appropriate ([see Section 4](#)).

All organisations need to consider their responsibility in relation to the gathering, storage, usage and sharing of personal information in line with the requirements of the Data Protection Act 1998, sometimes referred to as the principles of 'good information handling'.

### Data protection principles

Personal data:

- Shall be processed fairly and lawfully;
- Shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes;
- Shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed;
- Shall be accurate and, where necessary, kept up to date;
- Shall not be kept for longer than is necessary for the purpose or those purposes for which it was obtained;
- Shall be processed in accordance with the rights of the data subject under the Data Protection Act;



## Section 7

- Shall be protected against accidental loss or destruction of, or damage to, personal data by way of appropriate technical and organisational measures;
- Shall not be transferred to a country or territory outside the European Economic Area, <sup>13</sup> unless that country or territory ensures an adequate level of protection of the rights and freedoms of data subjects in relation to processing of personal data.

You should therefore ensure that your confidentiality policy specifies:

- What personal information is needed and why;
- How that information should be securely stored;
- Who should have access to information;
- How long information should be kept;
- With whom information should be shared;
- A vulnerable adult's right of access to his/her own records; and
- How records will be disposed of.

### 7.2 The policy informs staff and volunteers what information needs to be recorded.

All organisations need to ensure that they have essential personal details of all vulnerable adults for whom they provide services or activities.

Essential joining information should include:

- The name, address and contact number of all vulnerable adults and where appropriate their carers, advocates or next of kin;
- Any medical and health issues or particular requirements;
- Contact with other professionals/agencies, if any.

#### See Resource 7.1 – Sample Health Form

**Note:** Organisations providing Regulated Services will also need to take account of the regulations and associated Minimum Standards for these services.

#### See Appendix 2 – Standards

Organisations should also keep records, which reflect the vulnerable adult's ongoing engagement with the organisation. This will include records on attendance, activities participated in and any incidents/accidents/near misses that occur.

#### See Resource 5.2 – Sample Accident/Incident/Near Miss Record Form

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<sup>13</sup> Information on the countries within the European Economic Area can be obtained from UK Border Agency at [www.ukba.homeoffice.gov.uk](http://www.ukba.homeoffice.gov.uk)

### **7.3 The policy informs staff and volunteers how written records should be secured, stored and eventually disposed of.**

All written records should be stored in a secure location and accessed by authorised personnel only. Electronic records held on computers should also be appropriately secured by way of password protection and restricted access.

Information should be disposed of within timescales that are in keeping with the requirements of the Data Protection Act.

### **7.4 The policy outlines what and how information is shared with relevant people within and outside of the organisation.**

#### **Within the organisation**

Information should be shared within the organisation on a 'need to know' basis only. Line Managers will have access to information to check that records are being made and maintained appropriately and to enable them to identify patterns of behaviour emerging from incident reporting, which might give rise to the need to make a report to the Designated Officer in the local HSC Trust in accordance with procedures (see Section 4).

#### **Vulnerable adults, carers & advocates**

Vulnerable adults and their carers and advocates should be told how information will be used before they are asked to provide it and should be given an opportunity to discuss such uses.

This should be communicated in a way which is clearly understood, using alternative means of communication where necessary. Any information should be sought sensitively and with privacy.

When a vulnerable adult's information needs to be shared – for example, in cases of emergency or in the case of suspected abuse, the vulnerable adult and/or their carer or advocate should be told what information was shared as soon as possible, ensuring that this does not expose the vulnerable adult to further risk of harm.

#### **External agencies**

While information about vulnerable adults is confidential, it may be disclosed to external agencies to ensure the care and safety of an individual or of others or where a crime is suspected. This includes the disclosure of information to the HSC Trust or PSNI for such purposes.

### **7.5 Vulnerable adults involved with the organisation should have access to information held about them.**

Vulnerable adults should normally expect to see any information held by the organisation about them and should be so informed. This applies to paper and electronic records and should extend to access of a care record, unless any of the reasons for limiting access set out below apply. Access should be provided, if requested, to the vulnerable adult, and, with his/her consent to another person acting on his/her behalf (where possible all such requests should be received in writing). In any case, a record should be made of all requests received and their outcomes.

## Section 7

Where access is limited, this should also be recorded. For example, it may be necessary to limit access if: any part of the record contains confidential information about other people; or information was provided by another person or agency (such as doctor or other professional) and you have not been able to obtain their permission. It might also be necessary to limit access to information in circumstances where a care professional thinks access would cause serious harm to the vulnerable adult's or someone else's physical or mental well-being.

It is also helpful to set out the uses to which information may be put, for example to:

- Better manage, plan and improve the services/activities provided;
- Help train and teach staff/volunteers;
- Help with research, but only with the vulnerable adult's agreement; and
- Provide statistics about services/activities delivered by the organisation, noting that personal information is not used in this way and not shared with anyone other than in the circumstances set out above.

## Resource 7.1 Sample Health Form

### HEALTH FORM

#### IN CONFIDENCE

Name (organisation)	
Activity	
<b>PERSONAL DETAILS</b>	
Name (adult)	
Address	
Tel No	
Medical card number	
Are you taking any medication/treatment? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Please detail	
<b>CONTACTS FOR EMERGENCIES</b>	
Should be in a position to collect you if necessary.	
<b>CONTACT 1</b>	<b>CONTACT 2</b>
Name	Name
Address	Address
Relationship to you	Relationship to you
Home Tel No	Home Tel No
Work Tel No	Work Tel No
Other Tel No	Other Tel No

**Section 7**

<b>DOCTOR'S CONTACT DETAILS</b>
Name
Address
Tel No
<b>MEDICAL DETAILS</b>
Do you have any medical conditions? YES <input type="checkbox"/> NO <input type="checkbox"/>
Please detail
Do you have any allergies, including allergies to foods and medication? YES <input type="checkbox"/> NO <input type="checkbox"/>
Please detail
Do you have: Impaired hearing YES <input type="checkbox"/> NO <input type="checkbox"/> Impaired vision YES <input type="checkbox"/> NO <input type="checkbox"/>
Please detail
Are there any issues related to your: Physical health YES <input type="checkbox"/> NO <input type="checkbox"/>
Please detail
Mental health and emotional well-being YES <input type="checkbox"/> NO <input type="checkbox"/>
Please detail

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Awareness and decision-making skills	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Please detail				
Personal care & daily tasks	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Please detail				
Administration of medicines	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Please detail				
Walking & movement	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Please detail				
Communication & sensory functioning	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Please detail				
Any other relevant information:				
Please detail				

# Section 7

<b>CONSENT</b>
<input type="checkbox"/> I agree that the information provided may be shared with other staff/volunteers/ professionals who can contribute to providing me with a service or activity or care.
<input type="checkbox"/> I understand that I may withdraw my consent to share information or have further assessment at any time, but that this may affect ability to provide full services for me.
If there is any information on this form which you do not wish to be shared, please specify
1) which information you do not wish to share
2) who you do not wish to share information with
Signature
Date
Print Name
<b>IF SIGNED BY SOMEONE OTHER THAN THE VULNERABLE ADULT</b>
What is your relationship to the vulnerable adult?
On what grounds do you have the authority to sign on his/her behalf? <sup>14</sup>

<sup>14</sup> This should not be construed as being able to consent on behalf of the adult to whom this form relates.

# Section 8



**There is a written code that outlines the behaviour expected of all involved with the organisation, including visitors.**



## Section 8

### Standard 8

**There is a written code that outlines the behaviour expected of all involved with the organisation, including visitors.**

#### Criteria:

1. The Code of Behaviour (the Code) contains positive statements about how staff/volunteers are expected to behave towards vulnerable adults.
2. The Code outlines behaviours to be avoided.
3. The Code outlines unacceptable behaviours.
4. The Code contains guidelines relating to physical contact and intimate care.
5. The Code contains guidelines relating to physical intervention and restraint.
6. The Code contains guidelines relating to diversity and additional care and support needs.
7. The Code contains guidelines on the handling of vulnerable adults' money.
8. The Code contains guidelines on the use of technology, including photography.
9. The Code outlines sanctions in the case of staff/volunteers breaching the Code.
10. The Code sets out an expectation that everyone in the organisation and everyone who uses its services, participates in its activities or visits, should relate to each other in a mutually respectful way.
11. The Code is tailored to your services/activities.

### **8.1 The Code of Behaviour (the Code) contains positive statements about how staff/volunteers are expected to behave towards vulnerable adults.**

Having a Code of Behaviour for your organisation will minimise the opportunity for vulnerable adults to suffer harm. It will also help to protect staff/volunteers by ensuring they are clear about the behaviour that is expected of them and the boundaries within which they should operate. Many aspects of a Code of Behaviour are common sense but it is worth formalising these to ensure consistency of practice throughout the organisation. In terms of encouraging ownership, it is useful to involve staff/volunteers, vulnerable adults and carers/advocates in drafting and reviewing the Code for the organisation. The Code should be reviewed every three years or earlier if organisational changes make it necessary.

Standards of expected behaviour already exist for particular sectors, for example, the NISCC Codes of Practice for Social Care Workers and Employers of Social Care Workers. Organisations may find it useful to refer to sector-specific guidance when drawing up a Code of Behaviour for staff and volunteers.

#### **See Appendix 3 – Professional Regulatory Bodies**

Each organisation's Code will be different, reflecting the nature and activities of the organisation. It should provide a clear guide to your staff and volunteers on how they should behave when working with vulnerable adults. It should be a positive document highlighting positive behaviours as well as those to be avoided.

The NISCC Code of Practice for Social Care Workers sets out the following six positive statements which may be useful for organisations to refer to or tailor when developing their own Code of Behaviour.

Social care workers must:

1. Protect the rights and promote the interests of service users and carers;
2. Strive to establish and maintain the trust and confidence of service users and carers;
3. Promote the independence of service users while protecting them as far as possible from danger or harm;
4. Respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people;
5. Uphold public trust and confidence in social care services; and
6. Be accountable for the quality of their work and take responsibility for maintaining and improving their knowledge and skills.

### **8.2 The Code outlines behaviours to be avoided.**

The Code should also highlight the behaviours that should be avoided. These refer to behaviours that staff/volunteers may slip into through lack of experience or training. While not intentionally harmful, such behaviour might be misconstrued, which ultimately could lead to allegations of vulnerable adult abuse being made. For example:

## Section 8

Staff/volunteers should not:

- Spend excessive amounts of time alone with vulnerable adults away from others;
- Take a vulnerable adult to his/her own home;
- Take a vulnerable adult alone on car journey, unless this forms part of the organisation's core activities

If it is unavoidable or necessary, these kinds of behaviours should only occur with the full knowledge and consent of a manager and an appropriate record maintained.

### 8.3 The Code outlines unacceptable behaviours.

Unacceptable behaviours are those that should always be avoided in the interests of the safety of vulnerable adults, staff and volunteers. For example:

A staff member/volunteer should never:

- Abuse, neglect or harm or place at risk of harm vulnerable adults whether by omission or commission;
- Engage in rough physical games with vulnerable adults, including horseplay;
- Engage in sexually provocative games with vulnerable adults e.g. spin the bottle, strip poker;
- Make sexually suggestive comments to a vulnerable adult;
- Form inappropriate relationships with vulnerable adults;
- Gossip about personal details of vulnerable adults and their families; or
- Make/accept loans or gifts of money from vulnerable adults.

### 8.4 The Code contains guidelines relating to physical contact and intimate care.

Staff and volunteers should ensure that:

- Physical contact is person-centred and appropriate to the task required;
- They are trained to understand and implement a vulnerable adult's care plan, where required;
- When providing intimate care, it is done sensitively and with respect for the individual's dignity and privacy;
- If they are concerned about anything during intimate care, they report it to their Line Manager/Nominated Manager at the earliest opportunity.

### 8.5 The Code contains guidelines relating to physical intervention and restraint.

The guidelines should state that staff and volunteers should:

- Seek to defuse a situation, thereby avoiding the need to use any form of restraint;
- Only use restraint where it is absolutely necessary to protect the vulnerable adult or others from harm;
- Ensure that any restraint used is proportionate to the risk of harm;

- Only use forms of restraint for which they have received training and which follow current best practice;
- Record and report any use of restraint;
- Review any situation that led to the need for restraint with their Line Manager, with a view to avoiding the need for restraint in the future.

### See Appendix 5 – Useful Reading

#### **8.6 The Code contains guidelines relating to diversity and additional care and support needs.**

Staff and volunteers should:

- Be open to and aware of diversity in the beliefs and practices of vulnerable adults and their families;
- Ask how a vulnerable adult's care should be delivered, having regard to the cultural needs of others;
- Be aware of the difficulties posed by language barriers and other communication difficulties;
- Not discriminate against vulnerable adults and their families who have different cultural backgrounds and beliefs from their own;
- Use the procedures outlined in this Guidance to report any discrimination against vulnerable adults and their families by other staff members/volunteers.

#### **8.7 The Code contains guidelines on the handling of vulnerable adults' money.**

Staff and volunteers should:

- Maintain records of vulnerable adults' personal allowances, receipts and expenditure in line with organisational policy;
- Never deny a vulnerable adult access to his/her money;
- Never gain in any way when using the vulnerable adult's money on his/her behalf or guiding the vulnerable adult in the use of his/her own money;
- Never borrow money from, or lend money to, a vulnerable adult;
- Report any suspicions of financial abuse.

#### **8.8 The Code contains guidelines on the use of technology, including photography.**

New technologies, such as social networking websites and mobile phones, can be misused by those who are intent on harming or exploiting vulnerable adults.

## Section 8

Staff and volunteers should:

- Not photograph/video a vulnerable adult, even by mobile phone, without the vulnerable adult's valid consent;
- Ensure that any photographs/videos taken of a vulnerable adult are appropriate;
- Report any inappropriate use of images of a vulnerable adult;
- Report any inappropriate or dangerous behaviour on the internet that involves a vulnerable adult.

It is important that vulnerable adults are made aware of the dangers associated with new technology, such as social networking sites and the internet, and know to tell someone if they encounter anything that makes them feel unsafe or threatened.

### See Resource 1.2 – Consent

#### **8.9 The Code outlines sanctions in the case of staff/volunteers breaching the Code.**

Staff members and volunteers should understand that:

- If they are unsure of their actions and feel they may have breached the Code, they should consult with their Line Manager;
- Breaching the Code is a serious issue that will be investigated;
- Breaching the Code may result in disciplinary action and ultimately dismissal and if it constitutes harm/risk of harm, referral to the HSC Trust, police, ISA and regulatory bodies, as appropriate.

#### **8.10 The Code sets out an expectation that everyone in the organisation and everyone who uses its services, or participates in its activities or visits, should relate to each other in a mutually respectful way.**

It is essential to establish a set of ground rules in terms of the behaviour expected of staff, volunteers and vulnerable adults towards one another. For example, in relation to having respect for each other; avoiding the use of offensive language; use of alcohol, particularly on day trips; and sleeping arrangements on residential. The Code should be drawn up in consultation with staff, volunteers, vulnerable adults and carers/advocates, with the understanding that its breach by individuals using services could lead to their exclusion, or where the behaviour constitutes abuse, e.g. of a peer, referral to the police or HSC Trust for further investigation and action.

Carers and families or other visitors should also be made aware of the Code, in the expectation that they will also act in accordance with the Code when they are in contact with the organisation and any aspect of its work.

**8.11 The Code is tailored to your services/activities.**

As an organisation's Code of Behaviour should be a living document, the organisation should take time to develop a Code of Behaviour which is appropriate to its specific activities, rather than attempting to use an 'off the shelf' version created by another organisation. The importance of particular areas of the Code will depend on the nature of the organisation's activities, for example, handling vulnerable adults' money may not apply to some settings.

In terms of encouraging ownership, it is useful if everyone to whom the Code applies is actively consulted about what should be contained in the Code.

The Code should be used as a training tool at induction, where each element is explained and discussed with new staff and volunteers. It can also be used as a framework for discussion in support and supervision sessions, and ongoing training. It should be reviewed on a regular basis to take account of situations arising for the first time, for example, in relation to new technology and at least once every three years.

# Appendix 1

## The Safeguarding Vulnerable Adults Advisory Group

### Membership:

John Black	Regulation and Quality Improvement Authority
Kathleen Boyle	AgeNI
Alexa Brown	Autism Initiatives
Alison Conroy	Police Service of Northern Ireland
Gerardine Cunningham	Northern Ireland Social Care Council
Helen Ferguson	Carers Northern Ireland
Bill Halliday	Mindwise
Tim Kennedy	South Eastern Health and Social Care Trust
Mary McGoldrick	Independent Health Care Providers
Randal McHugh	Northern Health and Social Care Trust
Yvonne McKnight	Belfast Health and Social Care Trust
Joanne McWhirter	Alzheimer's Society
Rosemary Magill	Women's Aid
Gerry Maguire	Health and Social Care Board
Donna Moore	Simon Community
Brian O'Kane	Northern Ireland Housing Executive
Colette Slevin	Mencap
Sinead Twomey	Northern Ireland Housing Executive
Margaret Yarr	Church of Ireland
Michael McArdle	Department of Health, Social Services and Public Safety
Eilís McDaniel	Department of Health, Social Services and Public Safety
Pat Newe	Department of Health, Social Services and Public Safety
Dee Kelly	Volunteer Now
Rosie Oakes	Volunteer Now
Carol Twycross	Volunteer Now

### Terms of Reference:

- To represent their fields of interest and expertise in relation to standards of practice with regard to safeguarding vulnerable adults;
- To contribute organisational experience and expertise to ensure that project material produced is fit for purpose and takes account of research, learning and current best practice;
- To adhere to negotiated and agreed deadlines for receipt of comments, input and materials; and
- To meet once per quarter for the duration of the project.

### Acknowledgement:

A huge debt of gratitude is owed to the individuals and organisations that provided the benefit of their knowledge, expertise and experience to the Guidance. Thank you for your support, your time and your commitment.

# Appendix 2

## Standards

<b>MINIMUM STANDARDS</b>	<b>Available through:</b>
Nursing Homes - Minimum Standards Department of Health, Social Services and Public Safety, January 2008	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Nursing Agencies - Minimum Standards Department of Health, Social Services and Public Safety, January 2008	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Residential Care Homes - Minimum Standards Department of Health, Social Services and Public Safety, January 2008	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Domiciliary Care Agencies - Minimum Standards Department of Health, Social Services and Public Safety, 2008	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
As they become available, new Minimum Standards will be published on the Department's web site, <a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>	
<b>OTHER STANDARDS</b>	
Safeguarding Adults – A National Framework of Standards for good practice and outcomes in adult protection work	<a href="http://www.adass.org.uk">www.adass.org.uk</a>
The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HSC, Department of Health, Social Services and Public Safety, March 2006	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Standards for Adult Social Care Support Services for Carers Department of Health, Social Services and Public Safety, June 2008	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Improving the Patient & Client experience: 5 Standards: Respect, Attitude, Behaviour, Communication and Privacy and Dignity, Department of Health, Social Services and Public Safety, November 2008	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>



# Appendix 3

## Professional Regulatory Bodies

The Professional Regulatory Bodies are responsible for establishing and operating schemes of statutory regulation and professional standards relating to conduct and practice for organisations and individuals in their respective professions. Their aim is to protect the public and to develop their profession.

### General Chiropractic Council

General Chiropractic Council  
44 Wicklow Street  
London  
WC1X 9HL  
Tel: (020) 7713 5155  
Fax: (020) 7713 5844  
E-mail: [regulation@gcc-uk.org](mailto:regulation@gcc-uk.org)  
[www.gcc-uk.org](http://www.gcc-uk.org)

### General Dental Council

General Dental Council  
37 Wimpole Street  
London  
W1G 8DQ  
Tel: (020) 7887 3800  
Fax: (020) 7224 3294  
E-mail: [information@gdc-uk.org](mailto:information@gdc-uk.org)  
[www.gdc-uk.org](http://www.gdc-uk.org)

### General Medical Council

General Medical Council  
Regent's Place  
350 Euston Road  
London  
NW1 3JN  
Tel: 0845 357 0022  
E-mail: [practice@gmc-uk.org](mailto:practice@gmc-uk.org)  
[www.gmc-uk.org](http://www.gmc-uk.org)

## General Optical Council

General Optical Council  
41 Harley Street  
London  
W1G 8DJ  
Tel: (020) 7580 3898  
Fax: (020) 7307 3939  
E-mail: [goc@optical.org](mailto:goc@optical.org)  
[www.optical.org](http://www.optical.org)

## General Osteopathic Council

General Osteopathic Council  
176 Tower Bridge Road  
London  
SE1 3LU  
Tel: (020) 7357 6655  
Fax: (020) 7357 0011  
E-mail: [info@osteopathy.org.uk](mailto:info@osteopathy.org.uk)  
[www.osteopathy.org.uk](http://www.osteopathy.org.uk)

## General Teaching Council for Northern Ireland

General Teaching Council for Northern Ireland  
3rd Floor Albany House  
73 - 75 Great Victoria Street  
Belfast  
BT2 7AF  
Tel: 028 9033 3390  
Fax: 028 9034 8787  
Email: [info@gtcni.org.uk](mailto:info@gtcni.org.uk)  
[www.gtcni.org.uk](http://www.gtcni.org.uk)

## Health Professions Council

(At the time of writing regulates 15 professions including dietitians, occupational therapists and chiropodists)

Park House  
184 Kennington Park Road  
London  
SE11 4BU  
FREEPHONE: 0800 328 4218  
Tel: (020) 7840 9814  
Fax: (020) 7582 4874  
E-mail: [ftp@hpc-uk.org](mailto:ftp@hpc-uk.org)  
[www.hpc-uk.org](http://www.hpc-uk.org)

## **Northern Ireland Social Care Council**

Northern Ireland Social Care Council  
7th Floor, Millennium House  
19-25 Great Victoria Street  
Belfast  
BT2 7AQ  
Tel: (028) 9041 7633  
Fax: (028) 9041 7601  
E-mail: [conduct@nisocialcarecouncil.org.uk](mailto:conduct@nisocialcarecouncil.org.uk)  
[www.niscc.info](http://www.niscc.info)

## **Nursing and Midwifery Council**

Nursing and Midwifery Council  
23 Portland Place  
London  
W1B 1PZ  
Tel: (028) 7462 5800/5801  
E-mail: [fitness.to.practice@nmc-uk.org](mailto:fitness.to.practice@nmc-uk.org)  
[www.nmc-uk.org](http://www.nmc-uk.org)

## **Pharmaceutical Society of Northern Ireland**

Pharmaceutical Society of Northern Ireland  
73 University Street  
Belfast  
BT7 1HL  
Tel: (028) 9032 6927  
Fax: (028) 9043 9919  
E-mail: [complaints@psni.org.uk](mailto:complaints@psni.org.uk)  
[www.psni.org.uk](http://www.psni.org.uk)

# Appendix 4

## Useful Contacts

<b>Statutory Bodies</b>	<b>Contact</b>
Department of Health, Social Services and Public Safety	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Health & Social Care Board	<a href="http://www.hscboard.hscni.net">www.hscboard.hscni.net</a>
Public Health Agency	<a href="http://www.publichealth.hscni.net">www.publichealth.hscni.net</a>
Health & Social Care Trusts	<a href="http://www.belfasttrust.hscni.net">www.belfasttrust.hscni.net</a> <a href="http://www.northerntrust.hscni.net">www.northerntrust.hscni.net</a> <a href="http://www.setrust.hscni.net">www.setrust.hscni.net</a> <a href="http://www.southerntrust.hscni.net">www.southerntrust.hscni.net</a> <a href="http://www.westerntrust.hscni.net">www.westerntrust.hscni.net</a>
Patient and Client Council	<a href="http://www.patientclientcouncil.hscni.net">www.patientclientcouncil.hscni.net</a>
Health & Safety Executive	<a href="http://www.hseni.gov.uk">www.hseni.gov.uk</a>
Northern Ireland Housing Executive	<a href="http://www.nihe.gov.uk">www.nihe.gov.uk</a>
Regulation and Quality Improvement Authority	<a href="http://www.rqia.org.uk">www.rqia.org.uk</a>
Police Service of Northern Ireland	<a href="http://www.psni.police.uk">www.psni.police.uk</a>
<b>Advocates/Commissioners</b>	
The Older People's Advocate	<a href="http://www.olderpeoplesadvocateni.org">www.olderpeoplesadvocateni.org</a>
<b>Voluntary Organisations &amp; Service Providers</b>	
Action on Elder Abuse	<a href="http://www.elderabuse.org.uk">www.elderabuse.org.uk</a>
Age NI	<a href="http://www.ageuk.org.uk/northern-ireland">www.ageuk.org.uk/northern-ireland</a>
Autism Initiatives	<a href="http://www.autisminitiatives.org">www.autisminitiatives.org</a>
Autism NI	<a href="http://www.autismni.org">www.autismni.org</a>
Alzheimer's Society	<a href="http://www.alzheimers.org.uk">www.alzheimers.org.uk</a>
Belfast Carers' Centre	<a href="http://www.carerscentre.org">www.carerscentre.org</a>
Carers NI	<a href="http://www.carersni.org">www.carersni.org</a>
Counsel + Care for older people, their families and carers	<a href="http://www.counselandcare.org.uk">www.counselandcare.org.uk</a>
Extern	<a href="http://www.extern.org">www.extern.org</a>
Independent Health and Care Providers	<a href="http://www.ihcp.co.uk">www.ihcp.co.uk</a>
Mencap	<a href="http://www.mencap.org.uk">www.mencap.org.uk</a>
Mindwise	<a href="http://www.mindwisenv.org">www.mindwisenv.org</a>
Multicultural Resource Centre	<a href="http://www.mcrc-ni.org">www.mcrc-ni.org</a>

Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO)	<a href="http://www.niacro.co.uk">www.niacro.co.uk</a>
Northern Ireland Association of Mental Health	<a href="http://www.niamh.co.uk">www.niamh.co.uk</a>
Northern Ireland Women's Aid Federation	<a href="http://www.niwaf.org">www.niwaf.org</a>
North & West Housing	<a href="http://www.northandwest.org">www.northandwest.org</a>
Praxiscare	<a href="http://www.praxiscare.org.uk">www.praxiscare.org.uk</a>
Public Concern at Work	<a href="http://www.pcaw.co.uk">www.pcaw.co.uk</a>
Simon Community	<a href="http://www.simoncommunity.org.uk">www.simoncommunity.org.uk</a>
United Kingdom Homecare Association	<a href="http://www.ukhca.co.uk">www.ukhca.co.uk</a>
Volunteer Now	<a href="http://www.volunteernow.co.uk">www.volunteernow.co.uk</a>
<b>Others</b>	
Access Northern Ireland	<a href="http://www.accessni.gov.uk">www.accessni.gov.uk</a>
nidirect Government Services for Northern Ireland:	<a href="http://www.nidirect.gov.uk">www.nidirect.gov.uk</a>
The Care Tribunal for Northern Ireland	<a href="http://www.caretribunalni.gov.uk">www.caretribunalni.gov.uk</a>
<b>Helplines</b>	
Elder Abuse	0808 808 8141
Domestic Violence	0800 917 1414
Lifeline	0808 808 8000
ISA	0300 123 1111
AccessNI	028 902 59100
NIACRO (Belfast)	028 903 20157
Northern Ireland Housing Executive	03448 920 900

# Appendix 5

## Useful Reading

<b>Publication:</b>	<b>Available from:</b>
Adult Protection Toolkit for Domiciliary Care Agencies Action on Elder Abuse	<a href="http://www.ukhca.co.uk">www.ukhca.co.uk</a>
Clear Sexual Boundaries Between Healthcare Professionals and Patients, Council for Healthcare Regulatory Excellence, January 2008	<a href="http://www.chre.org.uk">www.chre.org.uk</a>
Elder Abuse Advocacy Toolkit Action on Elder Abuse	<a href="http://www.ukhca.co.uk">www.ukhca.co.uk</a>
Good Practice in Consent - Consent for Examination, Treatment or Care Department of Health, Social Services and Public Safety, March 2003	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Guidance on Restraint and Seclusion in Health and Personal Social Services Department of Health, Social Services and Public Safety, Human Rights Working Group, August 2005	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Safeguarding Vulnerable Adults - Regional Adult Protection Policy & Procedural Guidance Regional Adult Protection Forum, September 2006	<a href="http://www.hscboard.hscni.net">www.hscboard.hscni.net</a>
Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults Health and Social Care Board, Police Service of Northern Ireland & Regulation and Quality Improvement Authority, July 2009	<a href="http://www.hscboard.hscni.net">www.hscboard.hscni.net</a>
Seeking Consent: Working with people with learning disabilities Department of Health, Social Services and Public Safety, March 2003	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>

Seeking Consent: Working with older people Department of Health, Social Services and Public Safety, March 2003	<a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
Sexual Violence Directory of Services	<a href="http://www.nidirect.gov.uk">www.nidirect.gov.uk</a>
The Vetting & Barring Scheme Guidance March 2010	<a href="http://www.isa-gov.org.uk">www.isa-gov.org.uk</a>
ISA Referral Guidance March 2010	<a href="http://www.isa-gov.org.uk">www.isa-gov.org.uk</a>
ISA Decision Making Process Guidance August 2010	<a href="http://www.isa-gov.org.uk">www.isa-gov.org.uk</a>

# Appendix 6

## Organisational Self Assessment Checklist

### How to use...

This Organisational Self Assessment Checklist is a tool designed to help you assess where your own organisation is in relation to the criteria contained within each standard in Safeguarding Vulnerable Adults – A Shared Responsibility.

The Checklist will help you see which criteria your organisation is already meeting and which criteria are not currently being met and need attention, i.e. where policies, procedures and guidelines need to be developed.

When each of the criteria within a standard is met, then the standard is met.

An electronic version of this Self Assessment Checklist can be downloaded from [www.volunteering-ni.org](http://www.volunteering-ni.org) which organisations can use as a tool.



**Standard 1 – The organisation has a safeguarding vulnerable adult policy supported by robust procedures.**

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
			What?	By whom?	By when?	
<p><b>1</b> The organisation has a written safeguarding vulnerable adult policy (a safeguarding policy) statement which: acknowledges that all adults have the right to live a life free from abuse and exploitation; outlines the organisation's commitment to uphold that right; and is explicit about the organisation's 'zero-tolerance' of abuse wherever it occurs.</p>						
<p><b>2</b> The safeguarding policy should be 'owned' at all levels within the organisation. The Head of the organisation will direct the development of the policy, be responsible for its approval, and will ensure that it is fully implemented and reviewed.</p>						
<p><b>3</b> The safeguarding policy statement should be clearly displayed and everyone involved with the organisation should be aware that the policy exists, what it aims to achieve and the steps that will be taken to achieve those aims.</p>						
<p><b>4</b> The safeguarding policy should be supported by robust procedures and guidelines.</p>						
<p><b>5</b> The safeguarding policy should be supported by a Code of Behaviour for all involved with the organisation, including visitors.</p>						
<p><b>6</b> The safeguarding policy should be supported by other organisational policies and procedures aimed at promoting safe and healthy working practices.</p>						
<p><b>7</b> The safeguarding policy, procedures, guidelines and Code of Behaviour should be subject to regular review to ensure that they are fit for purpose; a review at least once every three years is the minimum recommendation.</p>						

**Standard 2 – The organisation consistently applies a thorough and clearly defined method of recruiting staff and volunteers in line with legislative requirements and best practice.**

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed		Attained Date
			What?	By whom? By when?	
<b>1</b> There is a clear job description for staff and role description for volunteers and a personnel/volunteer specification outlining the key skills and abilities and qualifications, if any, required.					
<b>2</b> There is an open recruitment process.					
<b>3</b> There is an application form that covers past work/volunteering.					
<b>4</b> There is a declaration and consent form requesting information on previous convictions and investigations, if any.					
<b>5</b> There is an interview process appropriate to the post/role and task.					
<b>6</b> Written references are sought (and followed up when necessary).					
<b>7</b> If a professional qualification is a requirement of the post, a registration check is made with the appropriate Professional Regulatory Body.					
<b>8</b> Where required, an AccessNI disclosure check and/or a check of Independent Safeguarding Authority registration is carried out.					
<b>9</b> The post is approved by management.					

**Standard 3 – There are procedures in place for the effective management, support, supervision and training of staff and volunteers.**

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed		Attained Date
			What?	By whom? By when?	
<p><b>1</b> There is an induction process into:</p> <ul style="list-style-type: none"> <li>• The organisation; and</li> <li>• The post/role.</li> </ul>					
<p><b>2</b> There is a probationary period for staff and trial period for volunteers.</p>					
<p><b>3</b> Relevant training is provided appropriate to the post/role.</p>					
<p><b>4</b> There is a robust structure and process for support and supervision appropriate to the post/role.</p>					
<p><b>5</b> There is an annual appraisal for staff and review for volunteers.</p>					
<p><b>6</b> Comprehensive, written records are kept of: training completed; support and supervision; and annual appraisals.</p>					

**Standard 4 – The organisation has clearly defined procedures for raising awareness of, responding to, recording and reporting concerns about actual or suspected incidents of abuse.**

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
			What?	By whom?	By when?	
<b>1</b> All staff/volunteers are aware of what is meant by vulnerability in adulthood, adult abuse, where abuse can occur and who can abuse.						
<b>2</b> There is a Nominated Manager who has responsibility for dealing with concerns about actual or suspected adult abuse, which come to light within the organisation.						
<b>3</b> There is a written procedure for staff/volunteers for responding to, recording and reporting concerns about actual or suspected adult abuse to the organisation's Nominated Manager.						
<b>4</b> There is a procedure for the Nominated Manager to report concerns about actual or suspected adult abuse to the appropriate authorities.						
<b>5</b> There is a procedure for reporting and responding to allegations made against staff and volunteers.						
<b>6</b> There is a system to communicate the reporting procedure to staff/volunteers to ensure they are familiar with it.						
<b>7</b> There is a whistleblowing policy and procedure.						

**Standard 5 – The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding vulnerable adults.**

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
			What?	By whom?	By when?	
<b>1</b> A risk assessment is carried out to identify and evaluate risks to vulnerable adults.						
<b>2</b> The identified risks are managed by putting in place risk-reducing measures.						
<b>3</b> All identified risks and risk-reducing measures are recorded and reviewed at least once per year.						
<b>4</b> The organisation should recognise that vulnerable adults have the right to take risks and should provide help and support to enable them to identify and manage potential and actual risks to themselves and others.						
<b>5</b> The organisation has a procedure in place for reporting, recording and reviewing accidents, incidents and near misses, which should in turn inform practice and the risk assessment and management procedures.						

**Standard 6 – There are clear procedures for receiving comments and suggestions and for dealing with concerns and complaints about the organisation.**

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed		Attained Date
			What?	By whom? By when?	
<p><b>1</b> The organisation has an ethos of inclusion, transparency and openness which is communicated to vulnerable adults, carers, advocates, family members, staff and volunteers.</p>					
<p><b>2</b> There are appropriate procedures in place for carers, advocates and vulnerable adults to share concerns they may have or to make complaints about the organisation.</p>					
<p><b>3</b> Complaints procedures are communicated appropriately to vulnerable adults, carers, advocates, staff and volunteers.</p>					

**Standard 7 – The organisation has a clear policy on the management of records, confidentiality, and sharing of information.**

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
			What?	By whom?	By when?	
<b>1</b> The policy is based on an expectation of confidentiality in the recording, use and management of personal information.						
<b>2</b> The policy informs staff and volunteers what information needs to be recorded.						
<b>3</b> The policy informs staff and volunteers how written records should be secured, stored and eventually disposed of.						
<b>4</b> The policy outlines what and how information is shared with relevant people within and outside of the organisation.						
<b>5</b> Vulnerable adults involved with the organisation should have access to information held about them.						

**Standard 8 – There is a written code that outlines the behaviour expected of all involved with the organisation, including visitors.**

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
			What?	By whom?	By when?	
<b>1</b> The Code of Behaviour contains positive statements about how staff/volunteers are expected to behave towards vulnerable adults.						
<b>2</b> The Code outlines behaviours to be avoided.						
<b>3</b> The Code outlines unacceptable behaviours.						
<b>4</b> The Code contains guidelines relating to physical contact and intimate care.						
<b>5</b> The Code contains guidelines relating to physical intervention and restraint.						
<b>6</b> The Code contains guidelines relating to diversity and additional care and support needs.						
<b>7</b> The Code contains guidelines on the handling of vulnerable adults' money.						
<b>8</b> The Code contains guidelines on the use of technology, including photography.						
<b>9</b> The Code outlines sanctions in the case of staff/volunteers breaching the Code.						
<b>10</b> The Code sets out an expectation that everyone in the organisation and everyone who uses its services or participates in its activities or visits should relate to each other in a mutually respectful way.						
<b>11</b> The Code is tailored to your services/activities.						





“

**Embrace this  
Guidance** and continue  
to work with us, to  
share the important  
responsibility of  
**keeping adults, who  
are vulnerable, safe  
from harm.** ”

**Michael McGimpsey**

*Minister of Health, Social Services and Public Safety*



**Volunteer Now**  
129 Ormeau Road, Belfast BT7 1SH  
Tel: 028 9023 6100  
[www.volunteering-ni.org](http://www.volunteering-ni.org)

**VOLUNTEER NOW**  
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Reference No: SG 33/12

<b>Title:</b>	<b>Safeguarding Children &amp; Young People who are admitted to adult wards for care and treatment.</b>		
<b>Author(s)</b>	Geraldine Sweeney Child Protection Nurse Advisor [REDACTED] [REDACTED]		
<b>Ownership:</b>	Mr Brian Barry SPECIALIST HOSPITALS, WOMEN'S & CHILD HEALTH SERVICE GROUP		
<b>Approval by:</b>	Standards and Guidelines Policy Committee	<b>Approval date:</b>	13/9/12 15/10/12
<b>Operational Date:</b>	December 2012	<b>Next Review:</b>	December 2015
<b>Version No.</b>	V1	<b>Supersedes</b>	Legacy policies relating to the admission of children and young people to adult wards.
<b>Links to other policies</b>			

<b>Date</b>	<b>Version</b>	<b>Author</b>	<b>Comments</b>
02.08.11	0.1	G Sweeney	Initial Draft
08.08.11	0.2	G Sweeney	BHCST minor changes
01.09.11	0.3	G Sweeney	BHCST minor changes
12.09.11	0.4	G Sweeney	BHCST minor changes
8/12/2011	0.5	JR Johnston	Formatting
15.11.11	0.5	G Sweeney	BHCST minor changes
13.12.11	0.6	G Sweeney	BHCST minor changes
07.02.12	0.7	G Sweeney	BHCST minor changes
14.02.12	0.8	G Sweeney	Final BHCST submitted for approval
5/03/2012	0.9	JRJ	Editing: New Template
02.05.2012	0.10	G Sweeney	BHCST minor changes following discussion at the Standards and Guidelines committee on 04.04.12
30/11/12	0.10	G Sweeney	No changes suggested at the regional group

## **Safeguarding Children & Young People who are admitted to adult wards for care and treatment.**

### **1.1 Background**

Belfast Health and Social Care Trust (BHSCT) aims to provide a high quality services to all children and young people requiring admission to hospital. Within BHSCT, children and young people may be admitted to an adult ward for care and treatment.

The Trust is committed to providing care for this group of children and young people within the framework of the Children (NI) Order 1995 and the Human Rights Act 1998.

It recognises that this group of children and young people are a distinct group with needs that will differ significantly from adults and younger children. As far as possible the Trust will seek to respect their need for individuality, increasing autonomy and independence.

### **1.2 Purpose**

This policy is for all staff members whose work brings them into contact with children up to the age of 18 years who are admitted to an adult ward. It will direct their practice to ensure that the needs of this group of patients are met during their stay in hospital.

### **1.3 Objectives**

- To provide a framework which guides staff in the decision making process regarding the safe admission of a child or young person to an adult ward.
- To ensure the child or young person's needs are paramount and central to decisions about admission and management.
- To enable staff to recognise and respond appropriately to the children and young people's needs.
- To inform families of the process by which decisions are considered, made and reviewed.

## **2.0 SCOPE OF THE POLICY**

This policy applies to children up to the age of 18 years.

## **3.0 ROLES/RESPONSIBILITIES**

### **Managers**

Managers at all levels are responsible for ensuring that staff are aware of the location of this policy, any amendments, and related policies.

Managers are also responsible for keeping staff up to date about any changes to this policy.

### **Ward Staff**

Staff must adhere to this policy and the Regional Child Protection Policy and Procedures (ACPC 2005).

All staff will have a responsibility to access the relevant child protection training.

#### **4.0 KEY POLICY PRINCIPLES**

##### **Definitions**

*'A child is a person under the age of 18 years as defined in the Children (NI) Order 1995.*

##### **4.1 In-Patients Admission**

Where children and young people are cared for in an adult environment, the following considerations should be made:

- 4.1.1 The care provided for each child should be sensitive to their individual needs and aspirations and take account of their race, ethnicity, gender, sexual orientation and ability or disability.
- 4.1.2 All children and young people admitted will be allocated a named consultant. Parents/carers will have access to the consultant in charge of their child/young person's care.
- 4.1.3 All children and young people admitted will have an allocated named nurse to act as advocate for them.
- 4.1.4 If the child/young person is unaccompanied on admission, nursing staff will inform the parent/carer and hospital social services if appropriate.
- 4.1.5 Each child/young person will have an individualised nursing assessment and care plan.
- 4.1.6 An assessment of risk and integrated planning is required to safeguard the best interests of the child/young person and to prevent isolation. Children and young people should be cared for in the open ward close to the nurse's station unless their medical condition or the ward environment dictates otherwise.
- 4.1.7 They should be cared for where possible with others of a similar age group and gender.
- 4.1.8 Every effort should be made to ensure the provision of appropriate facilities for young people with physical and/or sensory disabilities to encourage independence.
- 4.1.9 Ward staff must adhere to the Intimate Care guidelines (ACPC amendments 2008).
- 4.1.10 When a child /young person wants a parent or carer to stay overnight, appropriate facilities should be offered where available.
- 4.1.11 Discussion should be made with parents/ guardians regarding appropriate TV viewing and curfews.

4.1.12 If they are still in full/ part time education, the school or college should be notified by the parent. Children/ young people should be encouraged to continue their education in hospital except where their medical condition dictates otherwise. A referral should be made to the hospital school co-ordinator for those children/young people admitted for a prolonged period.

4.1.13 Ward staff should have an awareness of indicators which may suggest that a child is the subject of abuse or neglect and take appropriate action. It can also include concerns about the parents/guardian's behaviour or presentation.

## **4.2 Visiting Arrangements**

4.2.1 All of the points referenced in the Trust's Visitor Policy equally apply to children/young people. Information will be provided to the children and young people and their parents/carers in relation to visiting times and other services. Where possible open visiting arrangements should be made for close family members. The family should be encouraged to remain with the child/ young person during their admission.

4.2.2 When siblings or other children are visiting consideration must be given to location of the visit in relation to physical safety, comfort, privacy and dignity, access to toilet and general child-friendliness. Only in the most exceptional circumstances should visits be prevented due to environmental factors.

4.2.3 There should be a visible, vigilant staff presence evident at visiting times, to reduce potential risk to and vulnerability of the child.

## **4.3 Consent**

4.3.1 The rights of each child/young person must be respected. These include the right to dignity, privacy, confidentiality and appropriate information, including where possible, involvement in giving consent.

4.3.2 Only a person who legally has parental responsibility may agree to a child's treatment.

4.3.3 Once children reach the age of 16, they are presumed in law to be competent to give consent for themselves for their own surgical, medical, dental treatment or social care, and any associated procedures, such as investigations, anaesthesia, nursing or social care. However if a competent young person under 18 years refuses medical treatment without which she is likely to suffer significant harm, clinicians will need to consider whether the matter should be referred to the Courts for a declaratory judgement.

4.3.4 Where a competent child does ask you to keep his/her confidence, you must do so, unless you can justify disclosure on the grounds that you have reasonable cause to suspect that the child, or other children are suffering, or are likely to suffer, significant harm. You should however seek to encourage competent children to involve their family, unless you believe that it is not in their best interests to do so.

4.3.5 Unlike 16 or 17 year olds, children aged under 16 are not automatically presumed to be legally competent to make decisions about their health or social care. However, the courts have stated that a child aged under 16 will be competent to give valid consent to a particular intervention if he/she has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed known as “Frazer Principles”. In other words, there is no specific age when a child becomes competent to consent to treatment: it depends both on the child and on the seriousness and complexity of the treatment being proposed.

4.3.6 Further information is available from Seeking Consent: Working with Children (DHSSPS 2001).

#### **4.4 Parental Responsibility**

4.4.1 Only a person who legally has parental responsibility may agree to a child’s treatment on their behalf other than clinicians acting in their best interests. Not all parents will legally have parental responsibility.

4.4.2 The following applies to children whose birth is registered in Northern Ireland:

- A mother is automatically granted parental responsibility for her child.
- A father is automatically granted parental responsibility if he is married to the mother at the time of a child’s birth or they subsequently marry.
- For children born after 15<sup>th</sup> April 2002, an unmarried father has parental responsibility if he is named on the child’s birth certificate.
- Prior to this date an unmarried father may obtain parental responsibility through a formal parental responsibility agreement with the mother, or through the courts.
- Other people can acquire it though a Parental Responsibility Order, Residence Order and a Care Order.

#### **4.5 Staff Training**

4.5.1 All ward staff involved in the care of children/young people should have access to relevant training to enhance knowledge and skills enabling them to meet the needs of this age group. This includes mandatory child protection training which is available via TAS.



## 4.6

**What to do if you have child protection concerns about a child in your care:**

*The following action must not delay an immediate referral to Social Services where a child is suffering or likely to suffer significant harm.*

1. Discuss concerns with the parent/carer/child where appropriate, except where doing this would place the child at risk of significant harm, or compromise a possible police investigation. Parental consent to a referral to social services in relation to a **child protection concern** is not a requirement but, where possible, consent to such a referral should be sought.
2. In relation to **family support /"child in need" referrals** ward staff must seek the consent of the person who has parental responsibility for the child.
3. Seek medical attention if required.
4. Identify and discuss concern(s) with:
  - line manager;
  - hospital social worker;
  - named Safeguarding Children Nurse Specialist (SCNS)
  - or Gateway Team.
5. Document accurately all consultations with parents and or child and commence UNOCINI if appropriate.
6. During normal working hours (9am to 5pm) where there is a child protection concern ward staff should inform the hospital social worker who will complete an onward referral to social services if necessary.
7. Outside normal working hours (5pm to 9am) where there is a child protection concern ward staff should contact the Emergency Duty Social Work Team.
8. A management plan for the child should be jointly agreed between social services and ward staff to ensure the safety of the child.
9. These concerns and an appropriate management plan must be clearly documented in the patient's record. A copy of any completed UNOCINI form should be filed in the patient's record.
10. Written notification of any child protection concerns must be made to the relevant SCNS using the form in appendix 1. This form may be e-mailed to the SCNS as per Trust e-mailing policy.

## **5.0 IMPLEMENTATION OF POLICY**

### **5.1 Dissemination**

Dissemination of policy to hospital nursing staff via team meetings.

### **5.2 Exceptions**

Belfast Health and Social Care Trust (BHSCT) aims to provide a high quality services to all children and young people requiring admission to hospital. Within BHSCT children and young people may be admitted to an adult ward for care and treatment. This policy applies to staff working in adult wards who admitted children and young people. The exception to this is adult mental health and learning disability services who have existing procedures in place - 'Admission Protocol for Young People in the Care of care and Adolescent Mental Health Services who are admitted to Acute Adult Mental Health'.

## **6.0 MONITORING**

The policy will be reviewed every 3 years.

## **7.0 EVIDENCE BASE / REFERENCES**

1. Area Child Protection Committee's Regional Child Protection Policy and Procedures (2005)
2. Area Child Protection Committee's Intimate Care Policy and Guidelines (ACPC Amendments 2008)
3. Children and Young Peoples Strategy (OFMDFM 2006)
4. Co-operating to Safeguard Children ( DHSS&PS 2003)
5. Department of Health (1995) Children (Northern Ireland ) Order available at [www.hmsso.gov.uk](http://www.hmsso.gov.uk)
6. Human Rights Act (1998) available at [www.hmsso.gov.uk](http://www.hmsso.gov.uk)
7. Record Keeping – Guidance for Nurses and Midwives (NMC 2009)
8. Safeguarding children and young people –every nurse's responsibility, guidance for nursing staff (RCN 2007)
9. Seeking Consent: Working with Children (DHSSPS 2001)
10. Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008)
11. United Nations Convention on the Rights of the Child (1980)
12. Visitors Policy ( BHSCT 2008)

## **8.0 CONSULTATION PROCESS**

- Nurse Development Leads within hospitals
- Safeguarding Children Nurse Specialists
- Senior Nurse Management Team
- Named Doctor for Child Protection
- Northern Ireland Commissioner for Children and Young People
- John Growcott, Co-Director for Social Work Social Care Governance

**9.0 APPENDICES**

- Appendix 1 – Referral Form
- Appendix 2 - Safeguarding Children Nurses Specialists
- Appendix 3 - Flowchart for Making Referral to Family & Child Care Social Services

**10.0 EQUALITY STATEMENT**

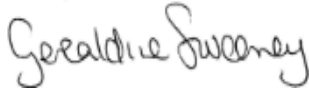
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact

Minor impact

No impact. x

**SIGNATORIES**



Date: 6/12/12

Name  
Title



Date: 6/12/12

Name  
Title

<b>BELFAST HEALTH &amp; SOCIAL CARE TRUST</b>			
<b>REFERRAL FORM TO SAFEGUARDING CHILDREN NURSE SPECIALIST FOR CHILD PROTECTION CONCERNS RELATING THE ADMISSION OF A CHILD/YOUNG PERSON TO AN ADULT WARD</b>			
<b>Ward admitted to:</b>			
<b>Date of Admission:</b>			
Patient's Name		D.O.B.	
Address:		Contact Phone Number	
Social Worker:		Health Visitor:	
G.P.:		G.P. Address:	
<b>Reason for admission and referral details:</b>			
Details of Children at Home:			
<b>Action taken:</b>			
Signed/Report completed by:			
Telephone Number:		Date:	

**Appendix 2****Safeguarding Children Nurses Specialists****Belfast City Hospital:**

Aideen McLaughlin

Mobile Number: [REDACTED]  
[REDACTED]**Mater Hospital:**

Aideen McLaughlin

Mobile Number: [REDACTED]  
[REDACTED]**Royal Hospital Group:**

Gill Hughes

Mobile Number: [REDACTED]

Monday, Tuesday & Wednesday 9 am-5.00pm  
[REDACTED]**Jane Thompson**

Mobile Number: [REDACTED]

Thursday & Friday 9am -5pm  
[REDACTED]**Musgrave Park Hospital:**

Jane Thompson

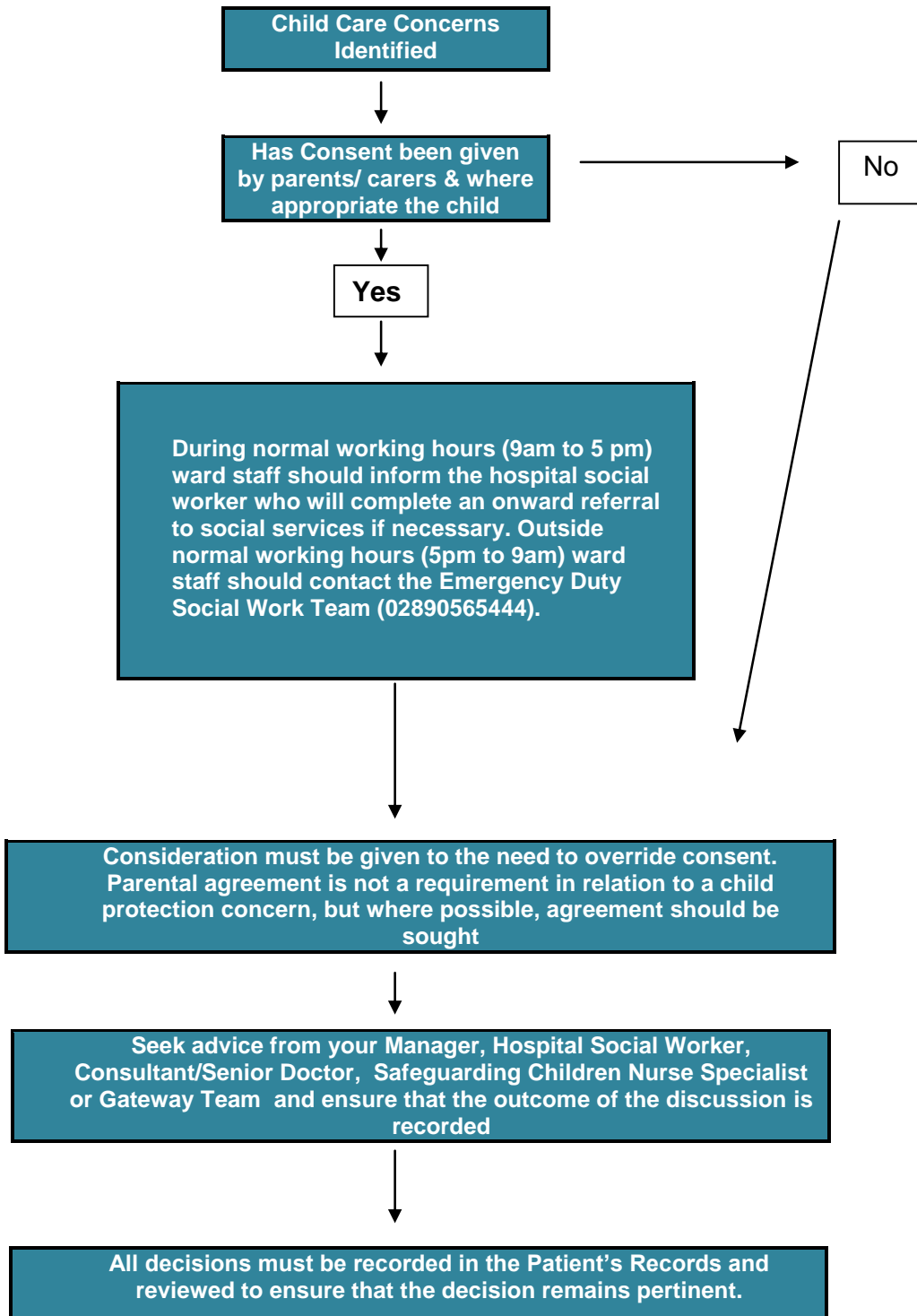
Mobile Number: [REDACTED]

Tuesday, Wednesday, Thursday & Friday 9am -5pm  
[REDACTED]

Monday 9am – 5pm contact the **Safeguarding Children Nursing Team Office –  
028 90265870**

**Flowchart for Making Referral to Family & Child Care Social Services**

**The following action must not delay an immediate referral to Social Services where a child is suffering or likely to suffer significant harm.**





The Regulation and Quality Improvement Authority

Safeguarding of Children and Vulnerable Adults in  
Mental Health and Learning Disability Hospitals in  
Northern Ireland

Overview Report

February 2013

informing and improving health and social care  
[www.rqia.org.uk](http://www.rqia.org.uk)

## **The Regulation and Quality Improvement Authority**

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health Social Services and Public Safety and are available on the RQIA website at [www.rqia.org.uk](http://www.rqia.org.uk).

## **Membership of the Review Team**

Theresa Nixon	Director of Mental Health and Learning Disability and Social Work
Patrick Convery	Head of Mental Health and Learning Disability
Margaret Cullen	Mental Health Officer/ Inspector
Rosaline Kelly	Mental Health Officer/ Inspector
Carolyn Maxwell	Mental Health Officer/ Inspector
Janet McCusker	Mental Health Officer/ Inspector
Audrey Murphy	Mental Health Officer/ Inspector
Patricia Corrigan	Project Administrator



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## Executive Summary

The Regulation and Quality Improvement Authority (RQIA) believes the right to be protected from abuse or harm is a fundamental principle underpinning the safeguarding of children and vulnerable adults. Individuals who are vulnerable because they lack capacity rely on others to keep them safe from abuse or potentially abusive situations. Those who abuse that trust are liable to prosecution under the criminal law.

RQIA is one of four organisations which collaborate to ensure that alleged and suspected cases of abuse of vulnerable adults are fully investigated and that measures are in place to offer appropriate protection. RQIA also works closely with other agencies to ensure appropriate measures are in place to protect children from abuse.

In April 2011 the Department for Health, Social Services and Public Safety (DHSSPS) commissioned RQIA to carry out a review of the effectiveness of safeguarding arrangements within mental health and learning disability (MHL) hospitals across the five health and social care (HSC) trusts in Northern Ireland.

RQIA's Mental Health and Learning Disability Team incorporated the theme of safeguarding into a planned programme of inspections for 2011-2012. This report summarises the findings from 33 inspections carried out between December 2011 and July 2012. It contains 26 recommendations to ensure the continued safeguarding and protection of children and vulnerable adults.

Inspectors found that all trusts had policies and procedures in place to keep people safe from the risk of harm and abuse. Trusts had established safeguarding partnerships to promote the awareness of safeguarding. Much effort has been made to ensure staff were appropriately trained.

Responsibility for safeguarding adults was vested in the Northern Ireland Adult Safeguarding Partnership (NIASP). At the time of the review, the Regional Child Protection Committee (RCPC) had responsibility for safeguarding and promoting the welfare of children. The new independent Safeguarding Board for Northern Ireland (SBNI) has now been established to include the duties of the former RCPC. These arrangements had not been fully reflected within the trust's safeguarding policies and procedures. Further work is required to ensure this occurs in a timely way.

Although there was evidence that safeguarding was being promoted, a common theme across all trusts was that there were instances where procedures were not always being appropriately and consistently applied.

To ensure that patients' rights are fully protected, there are areas that require improvement by trusts. These include: variation in thresholds for referring safeguarding concerns; the inappropriate use of restraint by untrained staff; and the lack of application of the correct procedures to protect patients' money and possessions.

Trusts need to continue their efforts to ensure staff are made aware of the indicators of abuse, and monitor closely the evidence of the effectiveness of the implementation of safeguarding policies, procedures and practices.

Inspectors noted the efforts made by all trusts to increase advocacy services for patients, but this was variable in some places. Discrepancies were noted in record keeping and many records were not appropriately signed. Assessments were not always updated and the types of interventions made were not appropriately recorded.

Recommendations for improvement are made within this report. These have been raised with the DHSSPS, HSC Board and with the trusts, through the inspection process.

In order that children and vulnerable adults are protected and kept safe from harm, the focus on safeguarding needs to continue to be a priority for all HSC organisations.

The findings of all adult mental health and learning disability inspections are reported on the RQIA website. The MHLD team also continues to follow up progress in respect of the implementation of the recommendations contained in the individual inspection reports.

## Section 1 – Introduction

### 1.1 Context for the Review

In April 2011 DHSSPS commissioned RQIA to carry out a review of safeguarding in mental health and learning disability hospitals. The purpose of the review was to consider and report on the effectiveness of the safeguarding arrangements in place within the MHL D hospitals across the five HSC trusts in Northern Ireland.

This review focused primarily on the arrangements in place to prevent abuse and assist staff to protect patients and themselves. The inspectors also examined a number of aspects of patient care and the findings are detailed in the individual inspection reports.

Safeguarding is a generic term which is used to describe the multidisciplinary measures put in place to minimise and manage risks to children and vulnerable adults. The safeguarding of children and vulnerable adults is a shared responsibility. Safeguarding arrangements require to be effective across a number of dimensions including awareness, prevention, identification and response.

To further develop the existing standards and guidance for safeguarding children and vulnerable adults, in 2009, DHSSPS introduced the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults.

For the purpose of this report, the term safeguarding refers to the HSC organisations' responsibilities to protect people whose circumstances make them particularly vulnerable to abuse. For adults, the definition of vulnerability is defined as:

“a person aged 18 years or over who is, or may be, in need of community care services, or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.”<sup>1</sup>

It is accepted that a person's need to be safe from harm is determined, not only by their individual circumstances, but also by the care setting they are in. Abuse may be committed as the result of negligence, ignorance or deliberate intent and targeting of vulnerable people, either in a single act or on a continuing basis.

At the time of the review, the definitions of abuse for both children and vulnerable adults were determined from available guidance. For adults, the

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<sup>1</sup> Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)

Safeguarding Vulnerable Adults Guidance (September 2006) defined abuse as:

“The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship.”<sup>2</sup>

For children, Co-operating to Safeguard Children (DHSSPS, 2003) document defined abuse as:

“Child abuse occurs when a child is neglected, harmed or not provided with proper care. Children may be abused in many settings, in a family, in an institutional or community setting, by those known to them, or more rarely, by a stranger. There are different types of abuse and a child may suffer more than one of them.”<sup>3</sup>

For the purposes of the inspections, forms of abuse were categorised as:

- physical abuse (including inappropriate restraint or use of medication)
- emotional abuse
- sexual abuse
- psychological abuse
- financial or material abuse
- neglect and acts of omission
- institutional abuse
- discriminatory abuse

In meeting the objectives of the term of reference, the review focused on:

- policies and procedures associated with safeguarding
- management, supervision and training of staff
- arrangements for the recruitment of staff
- awareness and response to safeguarding concerns
- identification and prevention of abuse
- concerns and complaints from patients and relatives
- records management arrangements

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<sup>2</sup> Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)

<sup>3</sup> Co-operating to Safeguard Children (DHSSPS, 2003)

Inspectors examined the safeguarding arrangements in place across the MHLD hospital wards in all five HSC trusts, including:

- children's learning disability wards
- children's and adolescent mental health wards
- acute learning disability wards
- acute mental health wards
- brain injuries units
- continuing care learning disability wards
- continuing care and rehabilitation units
- dementia wards and
- psychiatric intensive care units

Relevant legislation, policies, procedures, guidance and best practice documents were considered by the inspectors in their assessment of the effectiveness of each trusts' safeguarding arrangements.

Services or facilities excluded from this review included: those attended by children and vulnerable adults that are not either mental health or learning disability facilities; any MHLD services provided by private, independent and voluntary agencies; and the agencies and establishments (see Appendix 1) currently regulated by RQIA.

This report summarises the findings from these inspections and makes the recommendations necessary to ensure the continued safeguarding and protection of vulnerable adults and children.

## 1.2 Review Methodology

Seventy-two MHLD wards fell within the scope of this review. It was necessary to adopt a suitable methodology that would maximise the ability to validate the quality of safeguarding arrangements across the trusts. The review team agreed that validation of the safeguarding arrangements would be undertaken through a programme of announced inspections, carried out by RQIA's MHLD team. The rationale for this approach was to maximise the number of facilities inspected and make best use of the time available for discussions with management, staff and patients.

The Review Process:

1. Prior to the inspections 113 patient experience interviews were undertaken by RQIA from July to September 2011. Patients' views were used to inform the assessment of the effectiveness of the safeguarding arrangements in place.
2. Prior to inspection each ward completed a self-assessment questionnaire, detailing its safeguarding arrangements. Each HSC trust was also asked to complete a questionnaire regarding its corporate responsibility in all areas of safeguarding.
3. In view of the timescale for reporting, it was not possible to inspect all 72 MHLD wards. A proportionate risk-based approach was adopted to determine the wards to be inspected. Wards considered to have a higher risk rating, based on certain criteria, were selected over those wards that had a lower risk rating. RQIA's MHLD team analysed the available information on each ward and used the following risk based criteria to select the wards to be inspected:
  - intelligence and recommendations made from previous inspections
  - information gathered from patient experience reviews
  - information received from complaints and serious adverse incidents
  - the analysis of self-assessment questionnaires returned by the trusts
  - type of ward or service provided

From this analysis, 33 wards (four children's and 29 adult wards) were rated as high priority and selected for inclusion in the inspection programme (see Appendix 2). RQIA agreed with DHSSPS that this sample would provide an overview of the quality of safeguarding and safety arrangements across the five trust areas. While every effort was made to select wards in each trust based on the type of care provided, on occasion the need to inspect wards identified with a higher risk rating took precedence.

4. Each inspection examined aspects of safeguarding arrangements.  
Evidence to support the findings was drawn from:
  - meetings held with patients, staff and other professionals
  - an examination of patient case files, complaints and serious adverse incidents
  - an analysis of the findings from recent RQIA inspections and reviews.
  
5. In line with the methodology, two stages of reporting of the findings were agreed:
  - individual inspection reports would be produced for each ward and presented to the trusts in line with the normal inspection process.
  - a single overview report containing a summary of the regional findings would be produced for the DHSSPS.



## Section 2 – Findings from the Review

### 2.1 Background to the Findings

The findings of this review are presented under the following themes:

- governance arrangements both in the trust and in specific hospital wards
- the level of awareness of safeguarding arrangements and issues
- the ability of trust staff to recognise signs of abuse
- the mechanisms in place to prevent people experiencing abuse in the first place
- the procedures in place for staff to act appropriately if made aware of allegations or cases of abuse

In measuring effectiveness, it was important to recognise the broader context of practice and the internal and external challenges that impact on performance. It was not appropriate to judge safeguarding arrangements using a single effectiveness measure, as there are many components that need to be considered. Rather, different evidence was used to inform the development of indicators that could be used to assess the effectiveness of safeguarding arrangements.

Inspectors considered these would offer an appropriate basis for determining whether the safeguarding arrangements were sufficient to enable staff to effectively promote the welfare of children and vulnerable adults.

During the course of the inspections of the wards, issues were identified such as: a lack of consultation regarding human rights; environmental issues; and other areas not directly associated with safeguarding. Any issues identified during the inspection were brought to the immediate attention of relevant trust personnel for action, or raised under RQIA's escalation policy and procedure. The required action was detailed in the relevant quality improvement plan, for response by the trust.

The only provision for dedicated MHL D children's wards were in the Belfast Health and Social Care Trust (Belfast Trust) and the Western Health and Social Care Trust (Western Trust). The policy within the Western Trust was to minimise the admission of young people under 18 and to strive for a hospital at home model<sup>4</sup>. Although there were no children admitted to Crannog ward (Western Trust) at the time of the inspection, the ward still fell within the scope of the review and was inspected.

Although there were four dedicated MHL D children's wards, inspectors identified the continued admission of young people under 18 to adult wards in all trusts.

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<sup>4</sup> This enables specialist supports to be provided in the community as an alternative to hospital admission.

## 2.2 Governance Arrangements in Respect of Safeguarding

A successful safeguarding agenda requires the support of a wide network of agencies, organisations and communities of interest from across the statutory, voluntary, community, private and faith sectors.

Unlike child protection, prior to 2010 the coordination of arrangements for the safeguarding of vulnerable adults was limited. However, the recent work undertaken by DHSSPS and the Department of Justice (DoJ), formerly the Northern Ireland Office, led to the establishment of safeguarding partnerships and to the development of working groups to standardise regional policies and procedures.

### Adult Safeguarding Partnerships

While HSC organisations were able to clearly demonstrate their structures, governance and working arrangements, inspectors considered that safeguarding arrangements were in the early stages of development, as many policies and procedures were not updated. At the time of the review, the adult safeguarding partnerships had been in place for approximately 18 months. Inspectors considered that the publication of new regional adult safeguarding policy and procedures, completion of further safeguarding training for all staff, and the compilation of information on safeguarding are key factors requiring progression, to bring these partnerships to a more established stage of development.

Overall regional responsibility for adult safeguarding rests with the Northern Ireland Adult Safeguarding Partnership (NIASP), chaired by the HSC Board. The NIASP includes representatives from the statutory, voluntary, community and faith sectors. It has responsibility for the strategic direction and development of adult safeguarding throughout health and social care.

Within each trust area, a Local Adult Safeguarding Partnership (LASP) has been established, with responsibility for implementing the NIASP's guidance and operational policies and procedures at local level. Each LASP is chaired by an assistant director from the trust and includes representation from the trust and statutory, voluntary, community and faith sectors. The chairs of the LASPs are integral members of the NIASP, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered there is an effective infrastructure in each trust to support the operation of partnership groups. This includes sub-groups of NIASP, which lead in the areas of: policies and procedures; performance management and information; training; and communication and service user experience. During the review, some representatives of the partnerships suggested that the effectiveness of the sub-groups could be further improved by restructuring into trust led sub-groups, with a regional focus to improve practice.

Communication and reporting arrangements between the LASPs and NIASP were considered to be effective. LASPs regularly report on standards and outcomes such as training, trends, serious incidents related to adult safeguarding and vulnerable adult reviews. This information is used in the compilation of NIASP progress reports and a delegated statutory functions report is delivered annually by each trust to the HSC Board.

The only vacancy reported in the LASP, was one position within the Northern Health and Social Care Trust's (Northern Trust). This was in the process of being filled and was not adversely impacting on the activities of the group. Good attendance at NIASP and LASP meetings was reported, but attendance had fallen in both, particularly at the sub-group level.

### **Child Safeguarding Partnerships**

Well established child protection arrangements have been in place in HSC organisations for many years, in response to the events surrounding child abuse and historical child abuse inquiries. These focused more on child protection, than on wider aspects of safeguarding. However, this focus will change with the introduction of new child safeguarding legislation by DHSSPS and the establishment of new safeguarding structures. These new structures include a regional independent Safeguarding Board for Northern Ireland (SBNI) and five safeguarding panels located within each trust geographical area. These will mirror existing child protection arrangements, but with increased independence and direct accountability to the Minister for Health, Social Services and Public Safety.

As child protection partnerships have been in place for many years, HSC organisations were able to demonstrate evidence of appropriate structures, governance and joint working arrangements. At the time of the review, the Regional Child Protection Committee (RCPC) held overall responsibility for child safeguarding partnerships, which was chaired by the HSC Board. The RCPC is made up of representatives from the statutory, voluntary and community sectors and has responsibility for the strategic direction and development of child protection throughout Northern Ireland.

Considerable progress has been made in establishing new child safeguarding arrangements. During the transition period, the chair of the SBNI sat on the RCPC partnership, and the RCPC continued responsibility for child protection on an interim basis. During the review, it was established that the delay in transition of responsibility was impacting on the development of some aspects of child safeguarding arrangement, in particular, the development of up-to-date policies and procedures.

Within each trust area, a child protection panel (CPP) was established, with responsibility for implementing RCPC guidance and operational policies and procedures at local level. Each CPP was chaired by a trust assistant director and included representatives from the trust and the statutory, voluntary and community sectors. The chairs of the CPPs are also integral members of the

RCPC, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered that there was an effective infrastructure to support the operation of the partnership groups. Established RCPC sub-groups had taken a lead in the areas of: policies and procedures; case management reviews; education, training and audit; and communication and media management.

Communication and reporting arrangements between the CPPs and the RCPC are considered to be effective as there is a set of requirements for regular reporting and direct links for communication. CPPs regularly reported on standards and outcomes, which included statistical reporting, training, serious incidents related to child safeguarding and case management reviews. This information is used to compile RCPC quarterly reports and each trust's delegated statutory functions report to the HSC Board.

No vacancies were reported on the RCPC or CPPs, and attendance at their meetings was generally good. Inspectors noted that the position of the designated paediatrician for child protection within the HSC Board was vacant; however, another paediatrician was currently fulfilling the responsibilities of the post.

### **Policies, Procedures and Protocols**

While partnership groups were able to demonstrate a strategic plan for adult safeguarding, inspectors were concerned about the lack of an up-to-date regional policy and procedures for safeguarding vulnerable adults. Some trusts had developed their own policy and procedures in accordance with the DHSSPS regional guidance - Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (2006) and the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). Others had embraced the best practice elements from Safeguarding Vulnerable Adults - A Shared Responsibility: Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults (Volunteer Now, 2010). However, the most used guidance by most MHLD hospital settings was the 2006 document Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance<sup>5</sup>. Inspectors considered the 2006 document to be out-dated as it does not reflect current best practice for safeguarding vulnerable adults.

A NIASP sub-group has developed new draft operational policy and procedures for regional adoption, which are currently under review. However, given the direct relationship between these procedures and the development of an Adult Safeguarding Policy Framework being undertaken between DHSSPS and DoJ, the policy and procedures will not be released in advance of the Adult Safeguarding Policy Framework being published. Inspectors considered that until this is published, NIASP will be unable to fully deliver an

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<sup>5</sup> Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (2006)

effective safeguarding plan in the absence of up-to-date policies and procedures.

While children's partnership groups were able to demonstrate a strategic plan for child protection based on regional policy and procedures, few trusts had taken steps to further develop trust specific child safeguarding policy and procedures. With the transfer of responsibility to SBNI, both the regional policy and procedures and trust specific child safeguarding policies and procedures will need to be updated accordingly.

## **Patient Experiences**

An area that was not fully evident in the reporting process was that of the lack of reporting of adult patient experience. The inspectors considered that work on patient experience with adults, undertaken within the trusts, should be reported on and the information used to inform the commissioning of services by the HSC Board. NIASP has already been tasked with establishing arrangements for user engagement.

While work on patient experience of children has been initiated, it was not evident in the reporting process. The RCPC had already identified this gap and was planning to incorporate this in its work in the period before transfer to the SBNI. The communication between the SBNI and children and young people had already been established as a key priority of the new SBNI.

Inspectors considered that the newly established partnerships within children and vulnerable adult services provide effective arrangements in terms of leadership, governance, infrastructure, communication and reporting. This constitutes a sound foundation for safeguarding in Northern Ireland. The findings from inspections also indicated a number of on-going challenges, including the need for more direct patient experience and feedback; the release of revised regional policy and procedures; and the further development of the new safeguarding structures.

## **Recommendations**

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.
2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports to the HSC Board.

## 2.3 Awareness of Safeguarding Practice

The abuse of children or vulnerable adults can occur when a person is neglected, harmed or not provided with proper care. Raising awareness of abuse is one of the building blocks of effective safeguarding and not only enables staff within services to recognise and prevent it, but assists those at risk to recognise it and to seek help in protecting themselves.

For systems to be fully effective, all safeguarding arrangements must be promoted and not limited to the awareness of abuse. Staff must be familiar with the safeguarding structures within their organisation; understand their role and the roles of others; be aware of the policies and procedures; and know what action to take in relation to safeguarding issues. Similarly, patients and relatives should be made aware of the procedures and support arrangements associated with safeguarding.

Responsibility for safeguarding children and vulnerable adults is not specific to MHLA staff and applies equally across all services provided by the trusts. Information obtained during this review and also from the previous RQIA review of the Joint Protocol<sup>6</sup>, demonstrated that trusts had clear lines of management accountability and corporate responsibility in relation to safeguarding children and vulnerable adults.

Whilst structures associated with the safeguarding of children and vulnerable adults are in place, they differ from trust to trust. Each trust has representation at board and director level; designated officers<sup>7</sup> and investigating officers<sup>8</sup> for vulnerable adults; and designated paediatricians and named nurses for child protection. The effectiveness of the structures was confirmed by evidence of clear channels of accountability and communication. All trusts were able to demonstrate how they reported information from service level to trust board, and externally to the HSC Board. This included general information, performance returns, case management, risk management, governance oversight arrangements and information on the discharge of statutory functions.

On adult wards, inspectors considered that staff awareness of the designated officer role was not fully understood. However, in speaking with staff during inspections it was clear to inspectors that awareness of the role still not fully developed, as a limited number of staff were unsure of, or unable to identify the designated officer. Of the staff who replied to the questionnaires, approximately 15% claimed to be unable to identify their designated officer. A

<sup>6</sup> RQIA Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults

<sup>7</sup> Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance, defines the Designated Officer as: The person within the Trust deemed to be responsible for the decision to proceed under the Adult Protection Procedures and for coordinating any subsequent investigation which takes place.

<sup>8</sup> Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance, defines the Investigating Officer as: The experienced and suitably qualified professional appointed by the Designated Officer to carry out an investigation of the alleged abuse as agreed at the Strategy Discussion.

similar view was expressed by visiting professionals, such as consultant psychiatrists, social workers and therapists. Staff perceptions of their roles in relation to safeguarding vulnerable adults varied and was clearly linked to awareness and understanding received through training. Staff who had received training considered that it was mostly effective in terms of raising awareness of their roles in safeguarding vulnerable adults.

Each trust was developing the role of the designated officer and also the role of the investigating officer within MHLDS services, either in individual wards or in covering a hospital site. Inspectors considered this development to be beneficial in terms of improved communication, reporting and providing advice on adult safeguarding issues. The Northern Trust had the lowest number of designated officers, compared to other trusts. Its approach is to establish the number of designated officers proportionate to the level of safeguarding activity. The trust confirmed that the number of designated officers would increase if the level of safeguarding activity increased.

In relation to child safeguarding, the roles of designated paediatricians and named nurses were clear in all trusts and staff awareness was also very good.

All wards were noted to be proactive in promoting the awareness of child and adult safeguarding and had information regarding safeguarding displayed appropriately on notice boards. Posters and information leaflets were displayed at the entrance to wards to alert relatives and visitors. Policy and procedures and other information was available for staff in ward offices.

### **Training in Safeguarding Children and Vulnerable Adults**

Awareness of adult safeguarding and knowing what to do in a safeguarding situation can be improved through experience. If staff are to be equipped to deal effectively with an adult safeguarding situation, they must be appropriately trained. Approximately 66% of staff across the trusts were trained in safeguarding vulnerable adults. At the time of the review, only 16 wards were found to have had all staff trained in safeguarding vulnerable adults, although training schedules were noted to be in place for those who had not been trained.

On children's wards, child protection training was considered to be an integral element in maintaining appropriate child safeguarding arrangements. However, inspectors identified 16 staff working on the wards that had not received child protection training or training in Understanding the Needs of Children in Northern Ireland (UNOCINI)<sup>9</sup>. Inspectors expressed concern about this and recommended that all staff working on children's wards are appropriately trained in child protection

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<sup>9</sup> UNOCINI Guidance - Understanding the Needs of Children in Northern Ireland (Revised 2011)

## Knowledge and Awareness of Policy and Procedures

Effective adult safeguarding is unsustainable without appropriate guidance or policy and procedures. Arrangements for ward staff to access adult safeguarding guidance, policy and procedures were in place, with information being maintained and accessible either in hard copy or electronically via the trust's intranet. Inspectors identified that supporting procedures, such as the joint protocols<sup>10</sup> for investigations for both children and vulnerable adults and procedures for reporting and responding to allegations made against staff were absent from 15 wards across the Belfast (six wards), Western (five wards) and South Eastern Health and Social Care Trusts (South Eastern Trust) (four wards).

Staff awareness of each trust's policy and procedures for safeguarding vulnerable adults is an indicator of how alert an organisation is to the possibility of abuse occurring. During inspections, inspectors encountered a small number of staff in a few wards who claimed not to be aware of these policies and procedures. Even though it had been previously identified that not all staff across the trusts had completed safeguarding vulnerable adults training, inspectors considered that this was unlikely to be the primary contributing factor for the lack of awareness.

While trusts are taking positive steps in this area, inspectors considered that current regional guidance for adult safeguarding is not fully effective. Inspectors considered that the guidance was not up-to-date and did not reflect current best practice for safeguarding vulnerable adults. NIASP is in the process of developing a new operational policy and procedure. However, the delay in release of the revised guidance is having an impact on the ability of trusts to fully progress the adult safeguarding agenda at a local and regional level.

Guidance, policy and procedures for safeguarding children, the ACPC Regional Policy and Procedures (2005), were well established within all trusts and staff within children's wards were aware of them. Inspectors also observed appropriate policies and procedures specific to looked after children on the children's wards. The arrangements for staff on children's wards to access each trust's guidance, policy and procedures were considered to be effective, with information both available and accessible either in hard copy or electronically via trusts' intranets.

It was identified that supporting documentation on three of the four children's wards was outdated. Although these wards were aware of this, it was highlighted they had refrained from instigating any changes to documentation until the completion of the transfer of responsibilities and updated regional policies and procedures were available.

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<sup>10</sup> The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults and the Protocol for Joint Investigation by Social Workers and Police Officers, of Alleged and Suspected Cases of Child Abuse.



Policies and procedures to support adult safeguarding and child protection, such as policies for management of violence and aggression, restrictive practices and the use of restraint and physical interventions were in place across all trusts. The majority of staff across all trusts demonstrated an awareness of the supporting policies and procedures and how and where to access them, if required. However, on a small number of wards some of these policies were not up-to-date.

Effective awareness of safeguarding should not be limited to trust staff, but should include both patients and relatives. While wards were actively promoting safeguarding and raising the awareness through posters and information leaflets, many patients and relatives had little understanding or awareness of their respective trusts' safeguarding arrangements. On average, 42% of patients and 43% of relatives who responded during the review, claimed to be unaware that the ward had a safeguarding vulnerable adults policy. Inspectors considered patients and relatives should have been made aware of trust procedures in order to be able to reflect any safeguarding concerns.

### **Recommendations**

3. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.
4. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).
5. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.

## 2.4 Identification of Safeguarding Concerns

Determining whether abuse has occurred or not, can be a difficult task. To help to ensure effective safeguarding arrangements are in place, staff must be suitably skilled and competent in identifying signs of abuse and managing potential risks to vulnerable adults or children.

At the time of the review, inspectors were advised that about one third of staff had not received updated training in safeguarding vulnerable adults. While almost all staff were able to demonstrate good working knowledge and understanding of adult safeguarding and the types of abuse, a small number of staff were less able to demonstrate the same levels of knowledge or understanding. This was evidenced across all trusts during the inspection of wards.

The lack of ability to identify safeguarding issues was an area of particular concern to inspectors. Inspectors identified that on ten of the wards inspected, instances where safeguarding cases were not being classified by staff as a safeguarding concern. This meant that appropriate follow up and prevention mechanisms were not initiated. Such cases included patient on patient assaults or unexplained bruising. Lack of consideration of these incidents as possible abuse, was associated with what staff determined to be the threshold at which an incident should be designated as a safeguarding issue. In cases where a staff member is faced with doubt about a threshold decision, the appropriate course of action should be a referral to the designated officer for advice, but on occasions this did not occur. Nine wards received a recommendation in relation to the identification of threshold levels.

A lack of training was cited by some to be a contributing factor, however, not the only factor. Inspectors also found that a limited number of staff were unable to provide assurances that they fully understood safeguarding procedures and requirements, while others stated they did not feel confident in dealing with safeguarding issues, even after receiving training.

In light of this, inspectors considered that some aspects of safeguarding vulnerable adults training were not effective in providing staff with the understanding and confidence necessary to discharge their roles. A similar view was shared by a ward manager in one trust, who stated that clarification on the content of adult safeguarding training was required. Inspectors considered that the understanding of staff of the threshold level for reporting issues requires to be reviewed by NIASP.

### **Risk Assessment and Management**

Identifying potential risks and putting measures in place to deal with them are crucial in the prevention of abuse. All trusts have systems in place to identify and manage risks to patients, which included the use of the DHSSPS 2010 guidance on Promoting Quality Care (PQC).

Patient files were reviewed in all trusts and it was noted that risk assessments and care plans were completed for all patients. There was also clear evidence of these documents being reviewed and discussed at multidisciplinary team meetings, with many instances of the patients being involved. Information provided by relatives indicated that some considered they were not being informed or kept up-to-date with what was happening on the ward. Although this was not the case in all wards, many relatives expressed dissatisfaction with the feedback they had received from staff.

While patients in all trusts had received a risk assessment following admission to the ward, inspectors identified that the comprehensiveness of the documentation varied considerably between trusts. Concerns included:

- risks had been identified and recorded, but sometimes subsequent management plans had not been recorded in the notes, or notes were not correctly updated
- records were not updated to reflect patients' changing circumstances
- occurrences of risks that were considered to be serious had not been reviewed in detail
- some risks were not being recorded within the risk assessment
- patient assaults on staff were not reported as a risk

Staff indicated that assaults from patients formed part of the job; however, inspectors considered this may also be an indicator of potential risk to others and should be reported. A strategy should also be put in place to review, manage and minimise the risk.

Although each trust was able to demonstrate they had risk management systems in place, inspectors considered that staff on at least eight wards were not adhering or fully using the policy and procedures. A risk management plan is considered to be a live document and should be regularly updated to reflect any changes in patients' assessed needs and risks. Inspectors concluded that while the initial stages of the risk management process were being adhered to in all trusts, follow-up actions to update these documents were not always occurring. In the absence of updated and accurate patient documentation, arrangements to safeguard patients could be compromised.

All staff reported being aware of the risk assessment procedure. However, of the 345 staff across all trusts who replied to the questionnaires, approximately 61% advised of receiving training in how to carry out a patient risk assessment. While it is possible that not all staff would be required to carry out a patient risk assessment, inspectors considered this training would enhance their skills in the identification of risks.

Key indicators used in identifying child or adult safeguarding issues include accidents, incidents and near misses, where recurrences can highlight potential risks. It is important therefore, that trusts have in place procedures for reporting and recording accidents, incidents and near misses. Lessons can be learned from the analysis of these events which should be

disseminated to staff and used to inform changes in practice, policy and procedures.

### **Serious Adverse Incidents and Complaints**

All trusts had policies and procedures in place for recording and reporting accidents and incidents, supported by accident and incident log books on the wards. Staff demonstrated high levels of awareness of the accident and incident reporting process.

Each trust had its own individual reporting process and demonstrated how accidents and incidents were regularly reported and discussed at respective governance meetings. Mechanisms to bring risks and concerns to the attention of the trust board/ senior management were also in place. Evidence of the analysis and learning being fed back to the wards was presented, and staff also confirmed that learning was discussed at staff meetings.

Inspectors identified effective accident and incident reporting processes in place across all trusts to complement their safeguarding arrangements. However, the effectiveness of these processes was, on occasions, comprised by the lack of application of the procedures by some staff on at least seven wards. In particular, the previously identified problem associated with the threshold level for reporting an incident of abuse resulted in cases not being entered into the safeguarding process. These cases were not being investigated and learning from them could not be identified and shared appropriately with staff.

Other indicators applied to the identification of safeguarding issues include the concerns and complaints received from patients, relatives and staff. Information of this nature can highlight issues or cases of abuse never previously identified or reported. When patients, relatives or staff have a concern or complaint they should have access to the organisation's complaints procedure.

The arrangements for complaints were well established in all trusts, with policy and procedures in place in all wards, supported by robust recording and reporting mechanisms. All staff demonstrated a high awareness of the complaints procedures. However, just under 50% of staff who responded to the questionnaire indicated that they had received complaints training. The high levels of awareness in this area were attributed to staff experience of managing complaints over the years.

Inspectors considered that effective arrangements were in place for the handling of complaints in order to provide patients, relatives or staff the opportunity to have their issues addressed. However, awareness and access to the process needs to be addressed. It was identified on the majority of wards visited, that information regarding the complaints policy was displayed and was available either on a poster, in leaflets or both. Information regarding complaints was also included in the information packs provided for patients and relatives on admission. Even though this information was readily

available, patients and relatives still reported having low awareness. Of the wards inspected, 17 received a recommendation in relation to promoting the complaints procedure with patients and relatives. Of the remaining 16 wards, only a small number demonstrated evidence of being proactive in the promotion of the complaints procedure. Inspectors were unable to determine a reason for low levels of awareness of the complaints procedure among patients and relatives and considered this as an area the trusts should investigate further.

The awareness of whistleblowing and cases arising from it are becoming more prevalent and offers a further opportunity for the identification of safeguarding issues. All trusts have a whistleblowing policy which was observed on all wards visited and all staff indicated a high awareness of the policy. While inspectors considered that effective arrangements are in place in relation to whistleblowing, they considered that trusts needed to update their whistleblowing policies to indicate that RQIA is a designated body under the provision of the Public Disclosure (Northern Ireland) Order<sup>11</sup> which staff can contact if they are concerned about abuse.

### **Recommendations**

6. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.
7. Trusts should undertake an audit of practice to determine if all staff are robustly adhering to safeguarding policies and procedures.
8. Trusts should ensure that comprehensive investigations and risk assessments are carried out as required by relevant staff.
9. Trusts should ensure that risk assessment training is provided for all staff.
10. Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.
11. Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

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<sup>11</sup> The Public Interest Disclosure (Northern Ireland) Order 1998

## 2.5 Safeguarding Practice in Preventing Abuse

It is often difficult to prove that an abusive event has occurred and equally difficult to demonstrate that an abusive event has been prevented. Identifying what constitutes a successful preventative intervention is difficult to determine. It is for this reason that appropriate safeguarding prevention arrangements need to be in place. The prevention of abuse is preferable to supporting children or vulnerable adults after an abusive event has taken place.

Prevention is most likely to be effective where proper arrangements are in place such as: legislation and regulation; policies and procedures; training; awareness raising; information, advice and advocacy; interagency collaboration; and promoting the involvement of patients and relatives. However, the success of these arrangements will be determined by how well staff operate and adhere to them.

Appropriate recruitment and selection procedures are required to minimise the opportunity for unsuitable people to work with children or vulnerable adults. All trusts confirmed they had arrangements in place for vetting applicants, including carrying out pre-employment checks, requesting evidence of qualifications and registration with professional bodies, the provision of written references, and Access NI checks. Inspectors found these arrangements to be evident as protective measures in preventing unsuitable applicants from being employed by the trusts.

Good organisational practice requires a thorough induction process. In all trusts, new staff were required to undertake both a corporate induction and a local ward induction. Three trusts advised that the induction process included information on the trust's safeguarding arrangements. However, in the South Eastern and the Northern Trusts inspectors noted that safeguarding was not included in the corporate induction process. Inspectors considered this should be addressed, and safeguarding included as an integral part of all trusts' induction programmes.

Ward inductions tended to include reference to safeguarding arrangements. Evidence of the use of an induction checklist was observed on the wards. The only notable exception was in one ward in each of the Belfast and Western Trusts, where adult safeguarding was not observed to be part of the induction process. From observation of induction processes on other wards, inspectors considered the arrangements to be effective, as they provided an appropriate introduction to safeguarding for all new staff.

Good management of staff will ensure that everyone on the wards is clear about their roles and responsibilities in relation to safeguarding. Alongside the daily management responsibilities, supervision and appraisal should be available to assure the trusts that staff are carrying out their work to the required standard. Supervision is also essential to ensure that staff feel supported.

All trusts were noted to have policies and procedures in place for supervision and appraisal, although it was only in approximately half of wards visited that both processes occurred on a regular basis in line with the trusts' policies and procedures. Feedback from staff in these wards confirmed that regular supervision is offered and staff stated they felt supported by the ward manager. However, in 17 wards it was observed that no regular supervision was offered, or no supervision was taking place.

Appraisals had taken place in the majority of wards, with the exception of five wards in the Western Trust, where the absence of appraisals had been confirmed by staff. The Western Trust advised that in one instance this was due to no permanent ward manager being in place.

Inspectors considered there were effective arrangements in place to facilitate appropriate supervision and appraisal; however, these were not being applied consistently in 17 of the wards inspected. Inspectors also considered that by not adhering to supervision and appraisal procedures there is a risk that safeguarding arrangements may be compromised by the failure to identify potential safeguarding issues and staff training needs.

For those staff receiving supervision and appraisal, the tools used to identify training needs included personal development plans and the Knowledge and Skills Framework. While most staff members were satisfied that their training needs were being met, there were a couple of instances where staff indicated this was not the case, with a few staff stating they had found it difficult to access appropriate training or be released to attend training.

Safeguarding practices were assessed in several areas on the wards to determine what arrangements were in place and whether staff were adhering to best practice guidance, policies and procedures. The areas covered included aspects of care considered under the following headings:

- the practice of seclusion and restraint
- protecting patients' money and possessions
- visitation of children to the wards
- admission of young people under 18 years of age to adult wards
- management of records and record keeping

These areas must be properly managed and controlled to prevent potential abuse occurring.

### **The Practice of Seclusion and Restraint**

Inspectors examined the circumstances in which patients may be subject of seclusion and/or restraint, and the practice of close observation of both adult and children on wards. All trusts had policies and procedures for the management of interventions. Nine wards received a recommendation in relation to updating their policy on restraint, while on one ward within the South Eastern Trust, no policy on restraint was available.

Staff demonstrated good awareness of the need for documentation associated with close observation and restraint. Staff on two wards seemed less aware of the need to monitor seclusion and a recommendation was stated. The Southern and Northern Trusts advised of using seclusion as an intervention on a limited number of wards. Of the staff who responded in the questionnaire, approximately 49% advised of being trained in seclusion; however, this may be a consequence of seclusion no longer being practiced within three of the five trusts.

The numbers of staff trained in close observation and restraint was high, but not all staff had completed this training. Of the staff who responded, approximately 67% advised of being trained in close observation and 85% advised of being trained in restraint. To prevent unintentional abuse to patients, and to ensure staff are protected from inadvertently causing harm to a patient, inspectors considered that further training in this area is required.

The appropriate management of challenging behaviour could reduce the need for further interventions and limit the number of potential safeguarding cases. In the Western Trust it was noted that the use of de-escalation techniques had resulted in a reduction in the number of incidents of physical aggression. From the information provided by the five trusts, not all staff were trained in this area. The majority of staff were trained in de-escalation techniques and the management of challenging behaviour, the exception being the South Eastern Trust which reported having less than 50% of staff trained.

Throughout the trusts, it was observed that the application of policies and procedures for seclusion, restraint and close observation varied between wards. It was noted that the use of such interventions was only employed after discussion and agreement during multidisciplinary team meetings or after a risk assessment had been completed. A review of a number of patient records confirmed this to be the case and inspectors noted that staff were following the recommendations contained within patients' care plans. While there were areas of good practice, there were cases where the interventions had not been recorded or updated in patients' notes in eight wards and recommendations was stated. A concern was raised on five wards in relation to a small number of staff who were not adequately trained in applying behaviour intervention techniques on patients and a recommendation was stated. Since not all staff were fully adhering to the procedures and others were not fully trained, inspectors considered the arrangements for managing interventions could not be deemed to be fully effective.

### **Protection of Patients' Money and Property**

While children and vulnerable adults are in hospital, protection arrangements should be in place to safeguard their property and possessions. It was recognised that this was a difficult area to administer and manage, a view reiterated by staff across all trusts.

Where children and vulnerable adults are incapable of managing their affairs, suitable arrangements must be in place to protect them from financial abuse.



Each trust has arrangements in place which govern the management of patients' money, which include policies and procedures and mechanisms for receipt and storage of patients' property, including personal finance. The majority of staff in all trusts were familiar with the arrangements for handling patients' money. Staff expressed concern that the processes were applied on a trust wide basis and were not specific to MHLN wards, and suggested that further clarification was necessary.

Each trust had its own policy and procedure to govern patients' property. Patients were actively discouraged from bringing valuable items onto the wards. This was considered a sensible approach; safeguarding patients' property effectively requires trusts to redirect staff resources away from patient care.

When patients deposit money, it is recorded in an inventory book and deposited in the ward safe, a locked cabinet or lodged in the trust's cash office. Each ward had arrangements to allow patients access to their money. Even though patients and relatives did not raise concerns about the arrangements in relation to patients' money, inspectors identified issues in relation to how patients' money was managed. Records of expenditure were not always maintained. In particular, inspectors identified that on some wards, patient finances were used to purchase furnishings for the ward, such as curtains and bed linen. Trusts advised that such items could not be given to the patients upon discharge. This matter was raised with the trusts following the inspections.

In the management of patients' property, wards provided guidance and information to patients and relatives upon admission, used an inventory book to record patients' property brought onto the ward and provided patients with locked storage facilities. Relatives were also requested to label patient's property and clothing. Even with these arrangements in place, staff found this a difficult area to manage and patients regularly advised of items going missing. A contributing factor to this issue was that clothing and personal possessions were brought to and from the wards by relatives, which were not recorded in the inventory books. In these circumstances, staff had no way of maintaining an accurate inventory of patients' possessions. Inspectors considered that trusts had put basic arrangements in place to safeguard patients' property but considered that unless patients and relatives fully adhered to the arrangements, it was difficult to see how the wards could be expected to achieve effective oversight of this area.

Although there were policies and procedures in place, as well as mechanisms to record the receipt of patients' money, inspectors considered the current arrangements were not sufficiently robust to provide effective safeguarding of patients' finances. This matter is being closely monitored by RQIA. Inspectors also considered that guidelines on the use of patients' money needs to be further developed and communicated to all relevant staff.

## **Visits of Children to the Wards**

Children visiting parents and relatives is central to maintaining normal family relationships. However, the best interests of the child must be paramount and taken into account when considering a visit. All trusts have incorporated this into their safeguarding prevention arrangements and it has been outlined in policies and procedures for children visiting MHLA wards. This was not fully reflected in the practice observed on some wards.

While many staff on adult wards demonstrated awareness of the procedures associated with child protection, there were instances where the procedures were not available on the ward and staff did not know what the arrangements were. There was a perception from some staff that they did not require extensive knowledge of child protection, as they worked in predominantly adult services. Inspectors considered that these staff had failed to understand the importance of child protection issues of children visiting adult wards.

The number of staff on adult wards trained in child protection varied considerably across trusts, with an overall average of only 50% recorded as having received child protection training.

Information provided in relation to children visiting adult wards included posters, leaflets and a patient information booklet. This information was only observed on some wards throughout the trusts. In the Southern Trust it was observed that risk assessments were carried out prior to the child visiting, to allow for suitable monitoring arrangements to be put in place. In the Northern Trust, there was a protocol that stipulated that all child visits were to be pre-arranged with the ward manager. However, staff advised that this was difficult to manage as relatives did not adhere to this protocol and often arrived at the ward unannounced.

The physical arrangements in place on the wards to facilitate a child visiting varied considerably. While many wards had separate rooms to accommodate such a visit, many had no visiting area and some visits took place in the manager's office or the patient's bedroom.

Inspectors considered that the arrangements for children visiting adult wards are only partially effective, due to the lack of child protection training, staff understanding of the procedures and the lack of suitable visiting arrangements on the wards.

## **Admission of Young People Under 18 to Adult Wards**

In accordance with best practice, all children and adolescents should be accommodated within age appropriate services, rather than admitted onto adult wards. During the period from November 2010 to November 2011, a total of 71 admissions of young people under 18 to adult wards were reported by the five trusts.

All trusts had policies and procedures in place for the admission of young people under 18 to adult wards and staff demonstrated high levels of awareness in relation to this. Evidence was observed of wards adhering to the relevant guidance from DHSSPS and of the arrangements put in place by the trusts for such occurrences. These included: one-to-one nursing care; admission to single bedded rooms; and close observation. Admission of young people under 18 to adult wards is categorised as a serious adverse incident and requires notification to external organisations. Evidence of notification of these incidents to RQIA was presented to inspectors.

Inspectors were concerned about the level of adequate child protection training in respect of arrangements for the admission of young people under 18 to adult wards. Of the wards which admitted young people under 18, only one ward in the Western Trust was recorded as having all staff trained in child protection. The lack of staff with appropriate child protection training in the other wards was considered a potential risk to the safeguarding of children admitted to these wards. Inspectors recommended that immediate action is required in relation to child protection training.

### **Management of Records and Record Keeping**

As well as a requirement to implement best practice, the mechanisms that support robust safeguarding prevention arrangements, such as good records management, contribute in their own right to better safeguarding arrangements. Accurate recording of clinical outcomes, interventions, training and supervision help to ensure appropriate information is available for the purposes of patient care and also assists managers to identify gaps in staff capability that might impact on patient care.

Records management policies and procedures have been established in all trusts and schedules for auditing of records were identified by each trust. Staff demonstrated a high awareness of the procedures. However, information provided by staff indicated that on average, only 41% of staff had received records management training. In the majority of patient records reviewed, the notes reflected good record keeping, but there were some instances where information had not been recorded in line with trust procedures or best practice. In particular, discrepancies included: notes that had not been signed; risk assessments not being updated or completed; and interventions not having been recorded.

Records management procedures were also applicable to recording information about training, supervision and appraisal. Recording in this area was generally acceptable, with up-to-date information being maintained about staff training and the dates for supervision and appraisal. However, the review of records highlighted some gaps in mandatory training, out-of-date training and also that supervision and appraisal were not taking place. With such information readily available, the inspectors raised concerns in respect of the lack of application of training, supervision and appraisal.

While inspectors determined there were effective arrangements in place to facilitate best practice in records management, this area was only considered to be partially effective as there were too many instances where the procedures were not being followed.

### **Recommendations**

12. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.
13. Trusts should ensure that all staff receive regular supervision and appraisal.
14. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.
15. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.
16. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.
17. Trusts should ensure that only staff who are appropriately trained should employ restrictive intervention techniques.
18. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.
19. Trusts should ensure that all staff have received the appropriate level of training in child protection.
20. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.
21. Trusts should ensure that all staff receive training in records management.
22. Trusts should ensure that all staff adhere to the records management policy and procedures.

## 2.6 Response to Safeguarding Concerns

Even when organisations have arrangements in place to safeguard people from abuse, there can still be instances where abuse occurs. In such cases, it is the safeguarding response employed by the organisation that will determine whether appropriate action and support has been provided to individuals who may have been abused.

The response arrangements do not operate in isolation, or only when abuse occurs. These are intertwined throughout the policies, procedures and training, which are the mechanisms that enable staff to know how to respond following an incident of alleged abuse. The effectiveness of many aspects in these areas have been discussed throughout the report.

This section focuses on the arrangements for communication and the involvement of and support available for patients.

For people who experience abuse, the need to involve and work with other organisations is key in protecting them from further abuse. Promoting the welfare of patients is a joint responsibility that should be shared by a range of organisations. Engagement with other organisations was observed to be working well in all trusts. In particular, representatives from external organisations were represented on the RCPC, CPPs, NIASP and LASPs and were involved in serious case reviews. This was similar to the findings obtained during RQIA's Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (February 2012). Inspectors considered that the arrangements in place for liaison with other organisations were effective due to the multiagency approach, established lines of communication and regular meetings.

Each ward advised of promoting and communicating an ethos of inclusion and transparency to patients and relatives. While the majority of wards displayed a philosophy or mission statement either on the ward or in their information booklets, there were still a small number of wards where such information was not evident. It is therefore important to communicate a commitment to the principles of openness and transparency to patients, relatives, advocates and staff. Of the 33 wards inspected, 26 received a recommendation in relation to information provided to patients and relatives.

Although there was good communication throughout each trust, and externally to other organisations, inspectors identified that communication with patients and relatives was not always of an appropriate standard. Communication and involvement were also areas highlighted by both patients and relatives. While many felt they had received adequate communication, others were concerned about the lack of information regarding their relative's care and about incidents that happened on the ward. Across all trusts, patients' notes identified that many relatives were being informed about incidents, but other patients' notes and reports from relatives identified this practice was not happening routinely on all wards.

The inclusion of patients and relatives was often referenced in patients' notes; however, there were cases in each trust where they were not represented during discussions about care practices. Recommendations for involving patients and relatives were applied to 15 wards. The instances of weekly meetings with patients and relatives were limited to a few wards in each trust.

In terms of openness and transparency, a concern raised by many relatives was their access to the wards to see where their relatives were staying. All visits were facilitated in side rooms or outside the ward, with the exception of only a limited number of wards, where relatives were permitted access to the ward. While this practice was to facilitate ward routine and reduce disruption, relatives viewed it as a lack of transparency. In some cases the ward manager facilitated relatives access to the ward, but this was limited. RQIA believes that an appropriate balance needs to be struck between assuring relatives of the comfort of the ward, including sleeping arrangements, without comprising the privacy and dignity of the patients.

Patients' access to information held about them was considered an area that was not well promoted in most trusts and was further reflected in the comments from patients and relatives. While the trusts advised of having policies and procedures in place, it was determined these were simply freedom of information procedures. The South Eastern Trust had additional information about accessing personal information made available to patients on the wards. Inspectors considered the current arrangements were only fulfilling the minimum requirements in respect of access to information and considered that trusts should be more proactive in informing patients of their rights.

Where patients, relatives or their advocates have concerns or complaints about any aspect of treatment or care, they should have access to the trust's complaints procedure. Although there was evidence of relatives being encouraged to make a complaint in some patients' records, patients and relatives claimed not to be aware of the complaints procedures. From the patients and relatives who replied during the review, approximately 53% advised of being aware of their respective trusts' complaints policy. In 15 wards throughout the trusts, there was no evidence of informing or promoting the procedures to patients or relatives.

While the trusts strived to have a culture of openness and transparency in safeguarding practice, this was not evident on all wards. Inspectors considered the arrangements to promote inclusion were not sufficiently effective, as 15 wards received a recommendation in relation to involving patients and relatives. Although many mechanisms were in place to facilitate best practice, they were not being fully applied.

Advocacy services can make a significant contribution to the prevention of abuse, by enabling patients to become more aware of their rights and facilitating them to express their concerns. The availability of advocacy services varied considerably across trusts and between wards. Most wards

were promoting advocacy services to patients and relatives, through leaflets and posters. In a few wards, where advocacy services were available, the ward was not seen to be promoting this service to patients or relatives. To improve the advocacy arrangements for patients, 16 wards received a recommendation in this area.

Advocates spoken to during the review confirmed the benefits of promoting the services and reported an increase in the number of consultations. While many patients had access to advocacy services there were still a number of patients who were unable to avail of this service. The most proactive wards had patient advocates attending on a regular basis.

Inspectors considered the trusts were making good progress in providing advocacy services, but this should be available to patients in all wards.

### **Recommendations**

23. Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.
24. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.
25. Trusts should ensure that patients and relatives are fully communicated with in relation to their care, and about incidents and accidents on the wards.
26. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

## Section 3 - Conclusion and Recommendations

### 3.1 Conclusion

This report presents an overview of the safeguarding arrangements in place to protect children and vulnerable adults in mental health and learning disability hospitals across Northern Ireland. The recommendations apply to all trusts even though some may already be compliant. All five trusts have made good progress in establishing effective safeguarding arrangements for both children and vulnerable adults, although inspectors found that the levels of progress varied both across trusts and between wards.

Wards, where a designated officer or safeguarding lead was based or spent a considerable amount of time, demonstrated higher levels of safeguarding awareness, more up-to-date training, and the application of policies and procedures was more evident. The role of the designated officer is invaluable in establishing and delivering more effective safeguarding arrangements. Local and regional groups were established to facilitate multiagency working and clear communication protocols were in place for staff to report any concerns about the safeguarding of vulnerable people. Through these groups, trusts are able to share information, and to work on regional initiatives to drive further improvements in safeguarding practice.

The overall governance arrangements in place to support effective safeguarding were considered to be robust, with clear management and accountability structures evident in both children and adult wards.

Generally, the trusts have successfully determined the main priorities for safeguarding and maintained a focus on meeting these. However, the areas requiring progression were the development of the new adult safeguarding policy framework and the transfer of responsibilities for children to the new SBNI. Once in place a clearer focus can be brought to further improvements in safeguarding practices.

Most staff were able to demonstrate a basic awareness of safeguarding issues, of policies and procedures and of the required reporting arrangements. Improvement is required to ensure that all staff are trained appropriately in vulnerable adults and child protection procedures; that all relevant policies and procedures are updated and implemented; and that staff are proactive in the promotion of safeguarding processes to patients and relatives.

Inspectors found that different thresholds and mechanisms are being employed by trusts to identify potential safeguarding issues, such as patient risk assessments, reporting accidents and incidents and in the promotion of training in the complaints procedures. Although procedures are in place to support best practice, their effectiveness is being hindered by the lack of implementation by some staff. Although complaints policies and procedures are in place, 53% patients and relatives indicated through the questionnaires



that they were not familiar with or aware of them. The complaints process needs to be promoted further with patients and relatives.

The reporting and analysis of accidents and incidents is being carried out, but inspectors noted that many incidents had not been considered as a safeguarding concern and subsequently were not appropriately reported. There was evidence of risk management of patients and of risks being discussed at multidisciplinary meetings; however, there were instances where further follow-up was required. Further training is required to drive improvement in this area.

All trusts had effective arrangements in place to prevent unsuitable people working with children or vulnerable adults. Policies and procedures for supervision and appraisal were noted to be in place in all trusts. Many staff reported they were supported by management, but there were still cases where both regular supervision and appraisal were only being carried out in half of the wards visited.

All trusts had policies and procedures in place to prevent abuse. In some instances trusts' arrangements for managing patients' money and property were not wholly effective in providing adequate protection of patient money and belongings.

Although there was evidence of policy and procedures in relation to deprivation of liberty, a number of concerns were evident. Inspectors found that physical restraint was being applied by a small number of staff who were not appropriately trained. Nine wards received recommendations on updating their policy on the use of restraint.

Procedures were in place for children to visit adult wards. However, inspectors considered that the current arrangements on each ward should be reviewed to ensure that child protection procedures are being consistently followed. Further staff training in child protection in both staff in adult and children's wards is required, and this was recognised by the trusts.

The arrangements for responding to safeguarding issues varied across trusts. While arrangements for working with other organisations were in place, the internal arrangements and communication with relatives requires improvement in relation to the types and levels of information provided to them. Both patients and relatives should be consulted and involved more in decisions about safeguarding and patient care.

Advocacy services were available to most patients and relatives; however, inspectors noted many wards did not actively promote the services to patients or relatives. 16 wards required recommendations in this regard.

RQIA wishes to thank the management and staff from the Health and Social Care Board, the health and social care trusts, and all the patients and relatives who agreed to be interviewed for their cooperation and contribution to this review.

### 3.2 Summary of Recommendations

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.
2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports.
3. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.
4. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).
5. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.
6. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.
7. Trusts should undertake a review to determine if all staff robustly adhere to safeguarding policies and procedures.
8. Trusts should ensure that comprehensive investigations and risk assessments are carried out when required by relevant staff.
9. Trusts should ensure that risk assessment training is provided for all staff.
10. Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.
11. Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.
12. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.
13. Trusts should ensure that all staff receive regular supervision and appraisal.
14. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.

15. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.
16. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.
17. Trusts should ensure that only staff who are appropriately trained should employ intervention techniques.
18. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.
19. Trusts should ensure that all staff have received the appropriate level of training in child protection.
20. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.
21. Trusts should ensure that all staff receive training in records management.
22. Trusts should ensure that all staff adhere to the records management policy and procedures.
23. Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.
24. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.
25. Trusts should ensure that patients and relatives are fully communicated with, in relation to their care and incidents and accidents on the wards.
26. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

## **Glossary of Terms**

Belfast Health and Social Care Trust (Belfast Trust)

Child Protection Panel (CPP)

Department of Health, Social Services and Public Safety (DHSSPS)

Department of Justice (DoJ),

Health and Social Care (HSC)

Local Adult Safeguarding Partnership (LASP)

Mental Health and Learning Disability (MHLD)

Northern Ireland Adult Safeguarding Partnership (NIASP)

Northern Health and Social Care Trust's (Northern Trust)

Promoting Quality Care (PQC)

Regional Child Protection Committee (RCPC)

Regulation and Quality Improvement Authority (RQIA)

Safeguarding Board for Northern Ireland (SBNI)

South Eastern Health and Social Care Trust (South Eastern Trust)

Southern Health and Social Care Trust (Southern Trust)

Understanding the Needs of Children in Northern Ireland (UNOCINI)

Western Health and Social Care Trust (Western Trust)

## **APPENDIX 1 - Types of Agencies and Establishments Regulated by RQIA**

- Adult Placement Agencies
- Children's Homes
- Day Care Settings
- Domiciliary Care Agencies
- Nursing Homes
- Residential Care Homes
- Residential Family Centres

**APPENDIX 2 - List of Wards Inspected**

<b>Trust</b>	<b>Hospital</b>	<b>Ward</b>
Belfast Trust	Mater Hospital	Ward L
	Foster Green Hospital	Beechcroft Adolescent Unit
	Foster Green Hospital	Beechcroft Children's Unit
	Muckamore Abbey Hospital	Iveagh Centre
	Muckamore Abbey Hospital	Greenan
	Muckamore Abbey Hospital	Cranfield ICU
	Muckamore Abbey Hospital	Moyleena
	Muckamore Abbey Hospital	Finglass
	Knockbracken Healthcare Park	Avoca
	Knockbracken Healthcare Park	Valencia
Northern Trust	Causeway Hospital	Ross Thompson Unit
	Holywell Hospital	Inver 3
	Holywell Hospital	Carrick 4
	Holywell Hospital	Tardree 1
	Holywell Hospital	Inver 4
	Holywell Hospital	Lissan 1
South Eastern Trust	Lagan Valley Hospital	Ward 12
	Downe Hospital	Downe Acute
	Downshire Hospital	Ward 28
	Downshire Hospital	Ward 29
	Downe Hospital	Downe Dementia Ward
	Lagan Valley Hospital	Ward 11
Southern Trust	Longstone Hospital	Sperrin
	Longstone Hospital	Donard
	Longstone Hospital	Cherry Villa
	Longstone Hospital	Mourne
	St. Lukes Hospital	Gillis Memory Centre
Western Trust	Lakeview Hospital	Brooke Lodge
	Lakeview Hospital	Crannog
	Tyrone and Fermanagh Hospital	Ash
	Lakeview Hospital	Strule
	Waterside Hospital	Wards 1 and 3





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**SECTION 1****Title: Adult Protection Policy & Procedure****1.0 INTRODUCTION/PURPOSE OF POLICY****1.1 Introduction**

The Belfast Health & Social Care Trust recognises that abuse is a violation of an individual's human and civil rights. The Trust has a zero tolerance in relation to all forms of abuse and exploitation. The Trust is fully committed to ensuring that vulnerable adults who are subject to alleged, suspected or confirmed abuse are supported and protected from harm.

This Policy aims to ensure that all Trust staff and services commissioned by the Trust who are involved in the care of vulnerable adults who are subject to alleged, suspected or confirmed abuse, respond in a co-ordinated and consistent way to support and protect the Vulnerable adult.

The Belfast Health & Social Care Trust aims to deliver on Safeguarding Vulnerable Adults, the Regional Adult Protection Policy and Procedural Guidance (September 2006). It also seeks to embrace the wider remit of adult safeguarding and gives a commitment to provide advice and guidance to vulnerable adults who are subject to alleged or suspected abuse, irrespective of whether they match a specific service area/programme of care (see Section 3.4).

This Trust Operational Policy endorses legislative and regional requirements in relation to adult protection work. It is recommended that staff working in the field of adult protection read this document in conjunction with:

- Safeguarding Vulnerable Adults, Regional Adult Protection Policy & Procedural Guidance (Sept 2006)
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (Jul 2009)
- Achieving Best Evidence In Criminal Proceedings guidance for Vulnerable or Intimidated witnesses, including children (NI) 2012
- Human Rights Act 1998 enacted October 2000 which incorporates the European Convention of Human Rights and the fundamental Freedoms into UK Domestic Law
- DHSPPS Guidance on Consent & Capacity
- Regulation Quality Improvement Authority's Procedures for Responding to Allegations, Suspicions or Incidents of Abuse of Vulnerable Adults in Regulated Service (Nov 2007)
- The Safeguarding Vulnerable Groups Order (N.I) 2007 Vetting and Barring Scheme, as amended by The Protection of Freedoms Act 2012
- Adult Safeguarding in Northern Ireland – Regional and Local Partnership Arrangements (March 2010)

The Trust is committed to ensuring policies and procedures are reviewed and updated regularly. It is recognised that the DHSSPS are currently working on a new Regional Policy and this Belfast Trust Policy & Procedure will be reviewed as soon as the new Regional Policy is issued.

## 1.1 Background

The 'No Secrets: Guidance on Developing & Implementing Multi-agency Policies and Procedures to Protection Vulnerable Adults from Abuse' was issued by the Department of Health (2000) and required Trusts to work jointly with other relevant Agencies to protect vulnerable adults from abuse. This was followed by:

- Achieving Best Evidence in Criminal Proceedings (NI) Home Office 2002
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2003)

In 2006 Safeguarding Vulnerable Adults Regional Policy and Procedural Guidance was issued by the Regional Adult Protection Forum and endorsed by the DHSSPS. The Belfast Trust recognised this as the framework within which all work in relation to Adult Protection should take place. The Belfast Trust Adult Protection Operational Policy both endorses and complements the Regional Policy. It reaffirms the Trust's commitment to delivering on Regional Requirements and builds on this by setting out Trust requirements in relation to Governance arrangements.

## 1.2 Purpose

This policy is designed to provide a clear, comprehensive and consistent approach to the management of alleged, suspected or confirmed abuse of vulnerable adults within the Belfast Health & Social Care Trust. The Belfast Health & Social Care Trust is fully committed to delivering on Safeguarding Vulnerable Adults, the Regional Adult Protection Policy and Procedural Guidance (September 2006). The Adult Protection Procedures set out Trust expectations regarding reporting requirements and responsibilities in terms of investigation and protection of the vulnerable adult and is in keeping with statutory requirements. This policy will be relevant to a number of other Trust policies in certain situations and staff should be aware of the interface between this policy and other Trust policies. Other relevant Trust policies include:

- Whistleblowing Policy (Ref TP022/08)
- Policy and Procedure for the Management of Complaints & Compliments (Ref TP045/10)
- A Zero Tolerance Approach to the Prevention and Management of Violence and Aggression in the Workplace (Ref TP002/08)
- Belfast Health & Social Care Trust Policy & Procedural Arrangements relating to Lone Working (Ref TP021/08)
- Belfast Health and Social Care Trust Disciplinary Procedure (Ref TP052/08)
- Trust Protocol for Recruitment and Employment of Staff under the requirements of Safeguarding Vulnerable Groups (NI) Order (SVGO) 2007 and Vetting and Barring Scheme, as amended by the Protection of Freedoms Act 2012, Sept 2012 (Ref TP052/10)

- Adverse Incident Reporting and Management Policy (Ref TP008/08) and completion of Trust Incident form (electronic or paper)
- Procedure for Reporting Serious Adverse Incidents
- Use of Restrictive Practices in Adults (Ref SG0015/09)
- Provision of Trust's Domiciliary Home Care Services (Ref TP054/10)
- Policy for Staff Working in Trust Residential Homes for Older People (Ref TP046/10)

### 1.3 Objectives

1. The overall aim of the Policy is to prevent abuse by providing a framework within which all Trust staff should operate to protect vulnerable adults
2. To comply with Regional requirements as outlined / defined in 'Safeguarding Vulnerable Adult Protection Policy & Procedural Guidance (2006)'
3. To set out clearly the Trust's expectations in relation to identification and management of cases of suspected, alleged or confirmed abuse of a vulnerable adult
4. To clarify the roles and responsibilities of those involved in adult protection work
5. To ensure a comprehensive and consistent approach is taken in relation to adult protection work across the Trust
6. To promote effective multi-disciplinary and multi-agency working in relation to abuse investigations and protection planning
7. To highlight and reaffirm the Trust's commitment to Regional Protocols, in particular the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009) and meet requirements under Achieving Best Evidence in Criminal Proceedings (NI) Guidance for Vulnerable and Intimidated Witnesses including Children (2012)
8. To ensure early detection of abuse of vulnerable adults and prompt intervention to offer protection
9. To comply with current legislative requirements and to amend policy as required To reflect any future legislative changes
- 10 To provide a clear policy & procedures for managers and staff

## **2.0 SCOPE OF THE POLICY**

This Policy is relevant to all staff working within the Trust who, either directly or indirectly, come into contact with vulnerable adults who are subject to alleged, suspected or confirmed abuse. This Policy is of particular relevance to staff working within Older People Service, Learning Disability Services, Mental Health Services and Physical Health & Disability Services including Sensory Impaired. The Policy recognises that abuse of vulnerable adults can happen anywhere including Community, Hospital, Care Facilities and Day Care and the policy is therefore applicable in all settings. It covers all types of abuse including neglect and recognises that vulnerable people cannot always protect themselves. The document should also be read by providers of commissioned services as it sets out Trust requirements in relation to adult safeguarding/adult protection.

This Policy does not operate independently of other Belfast Trust Policies & Procedures. Policies and Procedures such as Complaints procedure and Disciplinary procedure should be implemented. Where an Adult Protection investigation is being conducted, the sequencing of implementation of other Trust policies & procedures will need to be carefully considered in order to ensure the protection of vulnerable adults.

## **3.0 ROLES/RESPONSIBILITIES**

To achieve these objectives, clarity regarding roles and responsibilities is required.

### **3.1 Trust Board**

1. To ensure that relevant Policies and Procedures are in place in relation to Adult Protection work
2. To commit appropriate resources to ensure that staff working in the field of adult protection are adequately trained

### **3.2 Service Group: Directors / Co-Directors / Service Managers**

To ensure that all staff within their areas of responsibility are familiar with the Trust's Adult Protection Policy and have a clear understanding of their role and responsibility.

To provide relevant training and support to staff to ensure they are adequately equipped to deliver in terms of their responsibilities in relation to adult protection work.

To ensure that the complement of staff trained as Designated Officers, Investigating Officers and Specialist Interviewers (ABE) is sufficient to meet the needs of the service.

To ensure that Trust specialist services contribute as appropriate to adult protection investigations and protection planning for example Trust Finance Department (Fraud Section) or Specialist Nursing Services.

### 3.3 Employees

To adhere to Adult Protection Policy & Procedure

To attend relevant training

To raise issues of concern promptly with line manager

To follow reporting procedures and protocols, with particular reference to Regional Reporting arrangements

To adhere to Protocol for Joint Investigation of Alleged and Suspected Abuse of Vulnerable Adults (2009)

Regulated Services must adhere to all the above and also to Regulation Quality & Improvement Authority reporting procedures

### 3.4 Staff trained in Adult Safeguarding

#### Designated Officer

Is a professional member of Trust staff who has received additional specialist Designated Officer training in relation to adult protection work. The Designated Officer has a number of key functions under the Adult Protection Policy. These include - deciding whether an investigation under Adult Protection Policy & Procedures is appropriate; nominating an Investigating Officer; providing line management support to the Investigating Officer; and overall responsibility for the co-ordination of the investigation, risk assessment and protection plan. The Designated Officer will determine whether the Protocol for Joint Investigation of Alleged, Suspected or Confirmed Abuse of a Vulnerable Adult (2009) should be initiated. Only staff trained and appointed as Designated Officers should fulfil this role.

#### Investigating Officer

Is a professional member of Trust staff who has had additional specialist training in relation to adult protection work. The Investigating Officer is responsible for conducting an adult protection investigation and for ensuring that an effective protection plan is in place. Only staff trained and appointed as Investigating Officers by their Service Group can fulfil this role.

#### Achieving Best Evidence Specialist Interviewer

Is a professional member of Trust staff who has successfully completed the eight day Achieving Best Evidence course. The role involves joint working with PSNI in terms of interviewing vulnerable or intimidated witnesses. Staff undertaking this role must have a detailed understanding of their roles and responsibilities as specified in the Achieving Best Evidence in Criminal Proceedings (January 2012). It is a regional requirement that staff trained as Specialist Interviewers should conduct a minimum of two ABE interviews annually in order to maintain their level of competency.

#### Staff trained in the Protocol for Joint Investigation

Most adult protection investigations involve a Designated Officer and an Investigating Officer. In cases where crime is suspected, a Joint Agency Consultation with PSNI should take place. If a joint investigation is initiated, staff trained in the Protocol for Joint Investigation can be nominated by the Designated Officer to gather preliminary



information to help inform the strategy planning meeting. Staff trained in Joint Protocol can also, in conjunction with PSNI, conduct a clarification discussion with a vulnerable adult. However it must be stressed that only staff trained as Specialist Interviewers under Achieving Best Evidence can conduct investigative interviews.

## **4.0 KEY POLICY PRINCIPLES**

### **4.1 Definitions**

#### Vulnerable Adult

The Trust has adopted the Regional Safeguarding Vulnerable Adults definition of a vulnerable adult as:

‘a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation’ (1). Therefore adults assessed by the Trust as eligible for a service from one of the service groups are defined as vulnerable adults.

This includes adults with physical, sensory and mental impairments and learning disabilities, howsoever those impairments have arisen, e.g. whether present from birth or due to advancing age, chronic illness or injury.

However, if there is an issue of alleged or suspected abuse, the Trust is committed to provide advice and guidance to potential vulnerable adults irrespective of whether they match a specific service area/programme of care. The Trust Protocol for responding to cases of alleged, suspected or confirmed abuse where the adult victim does not match programme of care definitions is detailed in Section 3.4

#### Abuse

The definition of abuse adopted by the Belfast Trust is derived from Regional Guidance issued by the Management Executive, Department of Health and Social Services, in 1996, which states that abuse is:

‘The physical, psychological, emotional, financial or sexual maltreatment or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship’ (2)

‘Forms of abuse can be categorised as follows:

- physical abuse (including inappropriate restraint or use of medication)
- sexual abuse
- psychological abuse
- financial or material abuse
- neglect and acts of omission

- institutional abuse
- discriminatory abuse

Incidents of abuse may be multiple, either to one person in a continuing relationship or service context or to more than one person at a time.

Any or all types of abuse may be perpetrated as the result of deliberate intent and targeting of vulnerable people, negligence or ignorance.

The Law Commission in its 1995 report makes use of the concept of significant harm as an important threshold when considering the nature of intervention and defines this as including not only ill-treatment (including sexual abuse and forms of ill-treatment which are not physical) but also the impairment of physical, intellectual, emotional, social or behavioural development. Significant harm may include the degree, extent, duration and frequency of harm (*see appendix 11 for more detail regarding categories of abuse*). Relevant Trust policies & procedures should be implemented and considered in relation to possible abuse situations, i.e. the Trust Policy in relation to Use of Restrictive Practices in Adults should be adhered to and considered when investigating allegations of inappropriate restraint.

## 4.2 Key Policy Statements

- The Belfast Trust recognises that the prevention of abuse of vulnerable adults is everyone's business and therefore requires all Trust staff and services commissioned by the Trust (private, voluntary, independent sector) to deliver a high standard of service.
- The Belfast Trust recognises that abuse of vulnerable adults is everyone's business and therefore requires all Trust staff and services commissioned by the Trust (private, voluntary, independent sector) to be alert to the possibility of abuse.
- Trust staff that have concerns regarding alleged, suspected or confirmed abuse of a vulnerable adult have a duty of care and are therefore required to report their concerns immediately. Staff reporting concerns regarding alleged, suspected or confirmed abuse will be expected to contribute fully to the investigation process. This may include an adult protection investigation, a disciplinary investigation and/or a PSNI investigation.
- All allegations of abuse of a vulnerable adult will be fully investigated and a protection plan put in place where appropriate.
- The Belfast Trust is fully committed to ensure that staff working with vulnerable adults meet legislative requirements as set out in the Safeguarding Vulnerable Groups Order Northern Ireland (2007) as amended by The Protection of Freedom Act 2012 and to ensure that future legislative changes are implemented. In keeping with this requirement the Trust have developed and comply with the protocol for the recruitment and employment of staff under the requirements of the Safeguarding Vulnerable Groups NI Order (SVGO 2007) and Vetting and Barring Scheme, as amended by the Protection of Freedoms Act 2012 (September 2012).

- The Trust will ensure that all staff working with vulnerable adults are appropriately trained in terms of adult protection work. Training will be commensurate with the individual's role and responsibilities. In regulated services, requirements regarding adult protection training and refresher training will be complied with, in keeping with Residential Home Regulations, Day Centre Regulations and Domiciliary Care Regulations. Reporting requirements in relation to regulated services will be strictly adhered to and RQIA procedures for reporting will be followed.
- Safeguarding Vulnerable Adults Regional Policy and Procedural Guidance (2006) will be fully implemented.
- In situations where alleged, suspected or confirmed abuse occurs, the Trust will act promptly to protect the individual and to investigate the abuse.
- Principles around consent and capacity will be adhered to and DHSSPS Guidance regarding consent and capacity will be applied.
- Any decision taken regarding the possibility of overriding consent will be carefully assessed and a clear rationale for overriding consent will be required.
- Human Rights legislation will be considered in all cases and the rights of the individual will be recognised as of paramount importance.
- The Trust will avoid unnecessary or premature initiation of a vulnerable adult investigation.
- In situations where an alleged perpetrator is a Trust employee, all actions necessary to protect the vulnerable adult will be taken. This will include consideration of disciplinary procedures, with particular reference to precautionary suspension or change of duties while the investigation is being conducted. Actions taken by the Trust will be both proportionate and least restrictive and will involve consideration of the Trust's dual obligations to the vulnerable adult and/or other vulnerable adults including children and its responsibilities as an employer to its employees.
- In all situations involving Trust employees (or paid carers), consideration will be given to referral to the Independent Safeguarding Authority. DHSSPS Guidance on Vetting and Barring will be applied (*See Trust Protocol for the recruitment and employment of staff under the requirements of the Safeguarding Vulnerable Groups (N.I) order (SVGO) 2007 and Vetting and Barring Scheme, as amended by the Protection of Freedoms Act 2012(dated September 2012).*)
- In all situations involving Trust employees, consideration will be given to whether referral to the person's professional body is appropriate. Trust processes should be referred to and followed where applicable.
- Where a crime is suspected, referral on to PSNI will be made by Trust.
- The Trust will work in partnership with the vulnerable adult, carers and relevant others.

- Multi-disciplinary and multi-agency working are recognised as key aspects of the work and the Protocol for Joint Investigating of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009) will be implemented where applicable.
- All services within the Trust are expected to report concerns regarding abuse of vulnerable adults to the relevant Service Group within the Trust. Regulated services must comply with all legislative requirements, i.e. Registered Homes (NI) Order, Domiciliary Care (NI) Order and Regulations and Day Care (NI) Order.
- Services commissioned by the Trust are required to comply with legislative requirements and regional policies, procedures and protocols. Furthermore, commissioned services must have in place adult protection arrangements that are compatible with the Belfast Trust's adult protection arrangements.
- Standardised recording and monitoring systems will be put in place.
- In keeping with Departmental requirements as set out in Adult Safeguarding in Northern Ireland Regional and Local Partnership Arrangements (March 2010), the Belfast Trust will have a nominated Trust wide Adult Safeguarding Lead at senior management level, will establish and chair a Belfast Local Adult Safeguarding Partnership and will provide and deliver on an annual Adult Safeguarding work plan which will be consistent with a regionally agreed Adult Safeguarding Strategic Plan.

## **5.0 IMPLEMENTATION OF POLICY**

### **5.1 Dissemination**

This Policy should be implemented by all Service Groups and all staff are required to comply with the Policy & Procedures. In order to ensure effective implementation the Belfast Trust has in place a Learning & Development Adult Protection training strategy. This strategy recognises that Trust staff are required to be aware of the policies and procedures in relation to Adult Protection work and their role and responsibilities within this. Staff need to be trained to a level commensurate with the responsibilities of their post.

An extensive training programme has been developed to ensure staff are provided with the necessary knowledge and skills to deliver, in terms of the obligations under the Adult Protection Policy.

The training programme consists of 5 levels of training:

#### Level 1 Awareness Raising Training – half day course

Mandatory for all Trust staff working with vulnerable adults. This session focuses on the alert stage of the policy. In addition and in keeping with Residential Homes regulations, Domiciliary Care regulations and Day Care regulations, refresher training is provided to all staff working in regulated service every 2/3 years as outlined in RQIA guidelines (every 2 years for domiciliary & day care, 3 years for nursing & residential staff).

Level 2 Training – one day course

Is aimed at first line managers and others who may be directly involved in the decision to refer to a Designated Officer (screening stage).

Level 3 Designated Officer/Investigating Officer Training - 2 day course

For staff who are directly involved in the investigation and management of adult protection work.

Level 4 Joint Protocol Training – 3 day course

Focuses on the Joint Agency Protocol; Joint PSNI and Trust training.

Achieving Best Evidence Training – 8 day course

Joint PSNI and Trust training.

In addition to training, implementation will also be supported by work of the Belfast Area Adult Protection Forum. To ensure ongoing development and support to staff working directly in Adult Safeguarding (Protection field), 3 practice support groups have been established for Designated, Investigating and ABE staff.

Trust best practice guidelines require Designated Officers and Investigating Officers to attend at least two practice support groups annually. These groups are facilitated on a quarterly basis March /June /September/December. Best practice would recommend that staff attend at least one practice support group every six months.

In addition to the ongoing training provided within the Trust as outlined above, additional information sessions will be organised to ensure that staff receive details regarding this updated policy. It is anticipated that full implementation will be achieved three months after policy approval. Any difficulty with this timescale should be brought to the attention of the author(s) of the policy.

## **6.0 MONITORING**

Each service group will be responsible for the day to day monitoring of this work and should have systems and processes in place to facilitate this. Each service group should ensure that relevant adult safeguarding issues are reported through their governance line to senior management. Monthly statistical returns will be completed by each service group, in keeping with Health and Social Care Board requirements in terms of monitoring activity and outcomes. An annual audit will also be conducted across the Trust in relation to various aspects of the policy. Regulated services will also be monitored via Regulation and Quality Improvement Authority.

## **7.0 EVIDENCE BASE/REFERENCES**

### **7.1 Evidence Base**

- 'Safeguarding Vulnerable Adults Regional Adult Protection Policy & Procedural Guidance' 2006
- 'Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' July 2009
- Adult Safeguarding in Northern Ireland – Regional and Local Partnership Arrangements (March 2010)
- Achieving Best Evidence in Criminal Proceedings January 2012

### **7.2 References**

- Law Commission for England and Wales (1995) Mental Incapacity Report No. 231 London HMSO (1)
- Guidance on Abuse of Vulnerable Adults (Management Executive Department of Health and Social Services 1996) (2)
- Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance (2006) (3)
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adult (July 2009) (4)

## **8.0 CONSULTATION PROCESS**

Senior staff within:

Older Peoples Services  
Physical & Sensory Disability Services  
Mental Health Services  
Learning Disability Services  
Trust Training  
Human Resources

**9.0 APPENDICES/ATTACHMENTS**

Appendix 1	Consent/Capacity/Human Rights Legislation
Appendix 2	Flow Chart - Referral/Investigation Pathway and Process for Older People and Physical Health and Sensory Disability Services
Appendix 3	Trust Adult Safeguarding Procedures Forms
ASP1 Section 1	Alert
ASP1 Sections 1 & 2	Referral
ASP1 Section 3	Screening
ASP2	Acknowledgement of Referral
ASP3	Significant interview
ASP4	Investigation & Assessment of Risk
ASP5	Protection Plan
ASP6	Minutes of meeting
ASP7	Human Rights
ASP8	Review of Protection Plan
ASP9	Closure / Transfer
Appendix 4	Emergency Duty Team ASP Form
Appendix 5	Domestic Violence Forms DASH/RIC MARAC forms
Appendix 6	Criminal Justice Secure Messaging
Appendix 7	Flow Charts re Hospital Settings
Appendix 8	Flow Chart re Regulated Services
Appendix 9	List of Key Trust Adult Safeguarding Staff Designated Officers Investigating Officers Achieving Best Evidence Specialist Interviewers
Appendix 10	Key Contacts – External Agencies
Appendix 11	Seven Categories of Abuse

**10. EQUALITY STATEMENT**

The outcome of the Equality Screening for this policy is:

- Major impact
- Minor impact
- No impact

The policy is aimed at protecting vulnerable adults including those with disabilities. Human rights considerations are integral to the decision making process within the policy and is evidenced through completion of all Adult safeguarding procedural forms.

**SIGNATORIES**

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



**Date: 17 April 2013**

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**Name Catherine McNicholl**  
**Title Director of Adult, Social and Primary Care**



**Date: 17 April 2013**

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**Name Colm Donaghy**  
**Title Chief Executive**



## **Procedures in relation to Adult Protection**

In keeping with Safeguarding Vulnerable Adults Policy & Procedural Guidelines 2006, the Belfast Health & Social Care Trust recognises that there are seven key stages in the process of dealing with an allegation or suspicion of abuse of a vulnerable adult.

It is critical at each stage in the following processes due consideration is given to Consent/Capacity and Human rights Legislation (see Appendix 1)

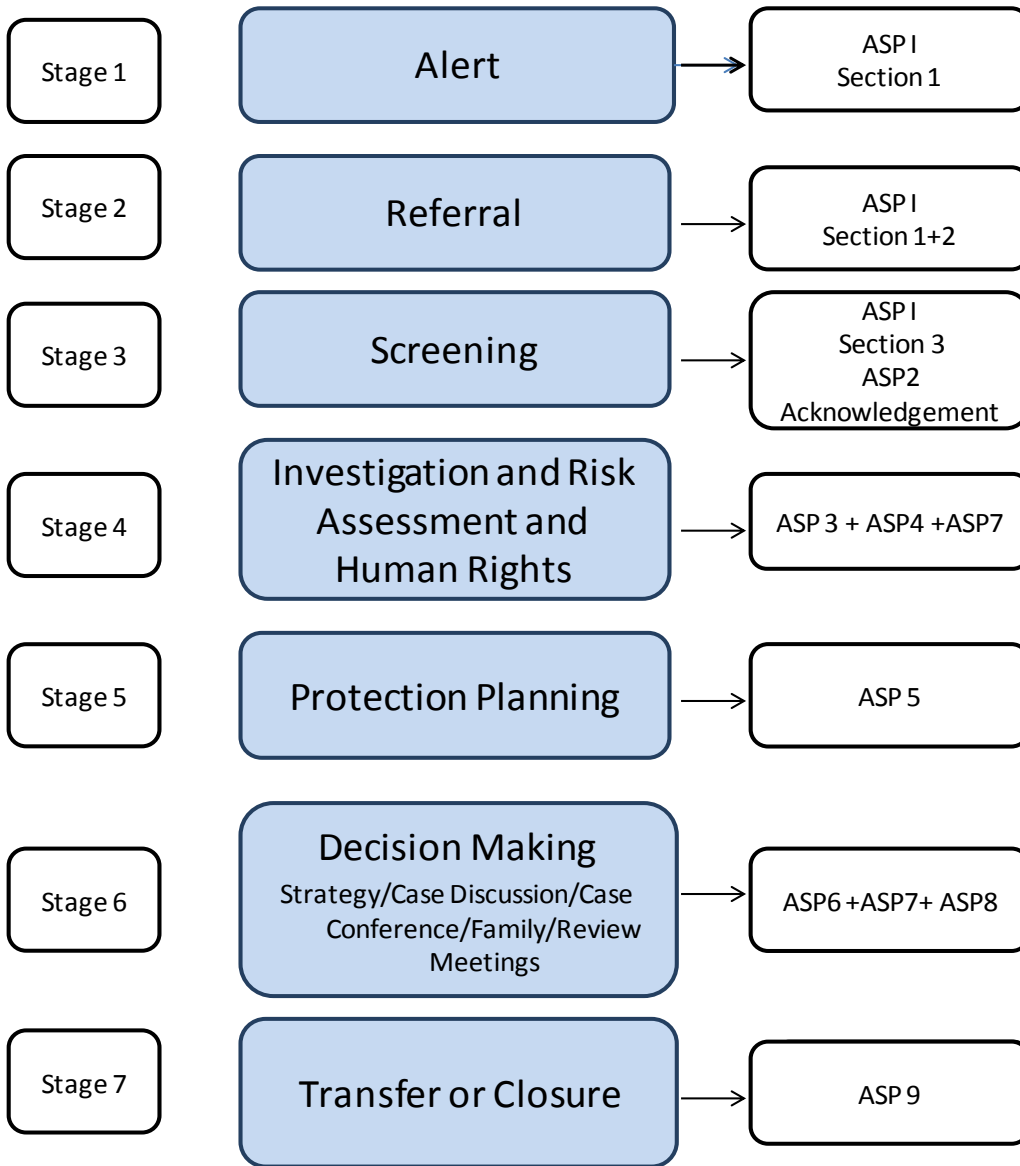
These stages are as follows:

- Alert
- Referral
- Screening
- Investigation and Human Rights
- Protection Planning
- Decision making
- Closure

The Belfast Trust Policy & Procedures seeks to provide staff with a clear understanding of their roles and responsibilities at each of these stages. It also recognises that it will not always be necessary to follow through all of these stages in every case. The flow chart below highlights the stages and the recording forms to be used at each stage.

A full set of Adult Protection recording documentation ASP1 to ASP9 forms is available on PARIS and on the Trust HUB (see Appendix 3 for hard copies).

## 2.1 SEVEN KEY STAGES OF ADULT PROTECTION PROCESS



## **STAGE 1**

### **2.2 Alerts**

All Trust staff have a responsibility to be alert to and recognise abusive situations and in these situations, where they have concerns to report this immediately to their Line Manager. All staff should be aware that they have a clear and explicit duty of care and therefore must report any alleged, suspected or confirmed abuse. The alerting stage plays a major role in ensuring the protection of vulnerable adults and it is important that all concerns regarding possible abuse should be reported.

If the allegations relate to a Trust employee, the staff member should alert their line manager. If the allegations relate to the Line Manager, the staff member should report the matter to a more Senior Manager. It should be noted that the Public Interest Disclosure (Northern Ireland) Order 1998 provides for the active safeguarding and protection of what are commonly known as 'whistle blowers'. Reference should be made to the Belfast Trust Whistle Blowing Policy 2008.

Staff who fail to report concerns regarding abuse could be subject to Trust Disciplinary procedures and sanctioned by their professional bodies, i.e. Nursing & Midwifery Council, Northern Ireland Social Care Council.

Concerns regarding suspected abuse by Trust staff who work in regulated facilities should also be reported to Regulation Quality Improvement Authority as outlined in RQIA Procedures for Responding to Allegations, Suspicions or Incidents of Abuse of Vulnerable Adults in Regulated Services (November 2007).

The criteria for referral to the Independent Safeguarding Authority should be considered where appropriate when the allegation relates to a paid staff member. If the allegation relates to a Trust member of staff, the line manager should report to their senior manager and a decision will be made regarding whether referral to the Independent Safeguarding Authority is appropriate. Reference should be made to the DHSSPS guidance on referral to Independent Safeguarding Authority (October 2009).

Providers of services commissioned by the Trust are required to notify the Trust of any concerns regarding alleged, suspected or confirmed abuse. Commissioned services are also required to have a Whistle Blowing Policy and Adult Safeguarding Policy and Procedures in place which are compatible with Belfast Trust policies and procedures.

In case of suspected abuse, the Line Manager should check that the vulnerable adult's immediate needs are being met, i.e. that there is no immediate danger and if required prompt medical assistance/assessment must be sought. If the vulnerable adult is in immediate danger, urgent action to protect the individual should be taken.

The line manager, along with the member of staff should determine whether the issue requires a consultation with a Designated Officer.

In situations where a consultation with Designated Officer does take place, consideration will be given to involving the vulnerable adult or carer if appropriate.

Where there is a difference of opinion between the line manager and staff member or where more guidance is required as to whether an investigation should be pursued, the line manager should consult with the appropriate Designated Officer.

In urgent cases, in the absence of the line manager, the member of staff should not delay the reporting of the incident and should contact a senior manager to discuss their concerns by telephone or in person. Any incidents arising outside normal office hours in the community/hospital/Care facility and requiring immediate intervention should be referred to the Emergency Duty Team (Out of Hours Social Work Team).

All cases of suspected, alleged or confirmed abuse should be recorded on the ASP1 form, Sections 1 by the reporting staff member in conjunction with their line manager. The actions which can be agreed by the line manager at this stage are as follows:

- No further action under Adult Protection Procedures
- Referral to the Quality Assurance Team (Older People and PHSD POC)
- Further screening / information required prior to a decision being made
- Referral to Designated Officer for screening under Adult Protection Procedures

The outcome should be recorded on the ASP form Section2

Should the line manager make the decision that there is no further action to be taken under the Adult Protection Policy, the ASP1 (Sections 1+2) form should be completed and filed in the client's records. A copy of the ASP1 form should be forwarded to the team leader on completion. The line manager should also ensure that a the concern is put as an alert on PARIS as follows 'Adult Safeguarding concern screened out' and add contact name and telephone number.

Where two or more ASP1 forms have been screened out in relation to the same client or facility consideration should be given to, whether collectively this information warrants further investigation under Adult Protection Procedures.

The relevant manager will collate and review the ASP1 forms which have been screened out under the procedures to satisfy him or herself that actions taken are appropriate. The appropriate manager will provide a crucial role in terms of identifying possible patterns or trends in keeping with Governance requirements and reports.

## **STAGE 2**

### **2.3 Referral**

Each Service Area will have their own complement of Designated Officers and Investigating Officers and a central register of Designated Officers is included in this document. Each service group must ensure that staff are kept updated re changes to this Register.

Cases concerning alleged, suspected or confirmed abuse should be referred to the appropriate Designated Officer. This contact can be made by telephone in first instance and should be confirmed in writing or electronically by the referrer within 2 working days on the ASP1 form (Sections 1+2).

Each Service group will have a system in place to respond to referrals/consultations. Each service group should also have in place a working protocol for the management of both internal and external referrals. All initial information provided by external referrers will be recorded on an ASP1 form by the relevant Designated Officer/Investigating Officer/Duty Officer.

The Designated Officer in consultation with the referrer should screen / assess available information to:

- Establish the substance of the suspected, alleged or known abuse.
- Confirm that the individual falls within the scope of the Policy

The actions which can be agreed by the Designated Officer at this stage are as follows:

- No further action under Adult Protection Procedures
- Further screening / information required prior to a decision being made
- Referral accepted under Adult Protection Procedures

The outcome should be recorded on the ASP1 form.

If a referral is accepted under Adult Protection Procedures the Designated Officer will complete ASP1 Section 3 and acknowledge the referral within two working days on an ASP2 form.

The Designated Officer is responsible for the ensuring that an alert is placed on PARIS as follows '**Adult Safeguarding involvement**' with name and contact details of Investigating Officer involved

It is also important that the person's Human Rights are considered at this stage. Unnecessary or premature initiation of a vulnerable adult investigation should be avoided.

It is important to consider issues of consent and capacity in order to establish the individual's ability to give meaningful consent to the abusive act or situation or to any further investigative process. DHSSPS guidance in relation to Good Practice in Consent should be followed when determining the individual's capacity and ability to consent. There will be some circumstances in which it will be necessary to override the wishes of an individual, even though they are deemed to be capable of giving meaningful consent. This occurs when:

- there is an overriding public interest or justification for doing so, i.e. a risk to a child
- a significant risk of death or serious harm to the vulnerable adult and/or others
- a serious criminal offence is suspected.

Each referral should be assessed by the Designated Officer to determine the degree of immediate risk and level of urgency in terms of response. Certain high risk situations will require an immediate response by Trust staff. *Examples of such a situation would include responding to need for medical assistance and/or referral to PSNI.* Staff should be aware of the need to preserve critical forensic evidence in certain circumstances, i.e. where there is an allegation of sexual abuse.

In all other circumstances allegations of abuse should be subject to initial screening/ investigation within 3 working days.

### **Out of Hours Referrals**

Any incidents arising outside normal office hours in the Community/Hospital/Care facility and requiring immediate intervention should be referred to the Emergency Duty Team (Out of Hours Social Work Team).

The EDT Duty Officer will complete the EDT ASP Section 1 (see Appendix 4) based on the information provided by the referrer and forwarded to the EDT Designated Officer who will record agreed actions in EDT ASP1 Section2

The Emergency Duty Team should give priority to the protection of the vulnerable person. They should also advise on any immediate investigative actions that are required such as referral to PSNI or preservation of forensic evidence. The EDT must report to the appropriate Trust Designated Officer on the first working day and forward the completed EDT ASP1 form.

All cases of alleged, suspected or confirmed abuse occurring within hospital settings, including Accident & Emergency, should be referred to the line manager and, if necessary, the Hospital Designated Officer (Senior Social Worker) during office hours. The Hospital Designated Officer will then liaise with the appropriate community Designated Officer to agree who will take the lead role. Alleged or suspected cases of abuse which occur within the hospital setting out of hours must be reported to the Senior Manager on duty within the hospital and to the Emergency Duty Team (Out of Hours Social Work Service) (*see Section 3.1 for more details regarding procedural requirements in relation A&E / hospital patients*)

RQIA must be notified in all situations where concerns have arisen in a regulated service or a commissioned regulated service. The RQIA's Procedure for Responding to Allegations, Suspicions or Incidents of Abuse of Vulnerable Adults in Regulated Services (Nov 2007) must be followed. This requires RQIA to be notified immediately of any alleged, suspected or confirmed incidents of abuse within any service it regulates, by the appropriate line manager and Designated Officer. RQIA Incident Reporting Procedures should be followed.

The Designated Officer will ensure that all incidents of alleged, suspected or confirmed abuse in Care Facilities (Statutory sector and Independent sector) or with Care Providers (Statutory and Independent) are reported to the relevant Service Area Manager and the Trust Quality Assurance Team.

### **Referrals concerning allegations against staff and paid carers**

All allegations of alleged, suspected or confirmed abuse of a vulnerable adult by a Trust employee should be considered under the following;

- Adult Protection Procedure
- Disciplinary procedures
- Joint Protocol Procedures

It will be the responsibility of the appropriate line manager to assess the initial information to determine whether an Adult Protection Investigation is appropriate. The line manager should also in consultation with Senior Management consider whether an investigation under Trust Disciplinary Procedures is required (refer to Section 3.3 for guidance).

Where the allegation constitutes a possible crime the line manager in consultation with the relevant Designated Officer should consider whether the Protocol for Joint Investigation applies. . Where there is a potential criminal investigation the Trust should be mindful that any action taken will not interfere with the PSNI investigation (refer to Section 3.3 for guidance).

### **STAGE 3**

#### **2.4 Screening by Designated Officer (to include initial strategy discussion)**

The Designated Officer will make an initial judgement based on referral information regarding whether further investigation is appropriate. In some situations it may be evident from the outset that a full investigation is appropriate. In other situations a further screening may be required.

Consideration should be given, in applicable situations, to the Trust Adverse Incident/Serious Adverse Incident reporting policy. Where the relevant criteria is met, a Trust Incident form (electronic or paper) should be completed.

Where appropriate, the Designated Officer will allocate the referral to an Investigating Officer. The Investigating Officer will take the lead role in carrying out the investigation, as directed by the Designated Officer.

Possible outcomes of screening may be that:

- Referral not appropriate for Adult Protection Procedures
- Further information required before an investigation is instigated
- Referral accepted for investigation under Adult Protection Procedures
- The Designated Officer will consider whether the Protocol for Joint Investigation of Alleged and Suspected Abuse of Vulnerable Adults is relevant and refer to PSNI if appropriate.

Where there is a decision that a referral is not appropriate for adult protection at this stage, the Designated Officer should record the decision on Section 2 of the ASP1 and forward to the referrer/line manager.

Each Service Group will nominate either the Team Managers and/or a Senior Manager who will be responsible for the collation and review of information received.

In all cases of alleged, suspected or confirmed abuse, the key priority will be to protect the vulnerable adult from further abuse. The protection planning should begin as soon as an allegation of abuse is made and will be a key consideration for the Designated Officer and the Investigating Officer at all stages in the investigation process.

At the point of referral a Strategy Discussion will take place to ensure an early exchange of information and to clarify whether there is a need for any immediate action to be taken. The Strategy Discussion may take place by telephone but in particularly complex referrals, there may be a need for a Strategy Discussion meeting. Strategy Discussion via telephone should take place within one working day of referral to the Designated Officer, unless good practice dictates otherwise. Where a Strategy Meeting is required, this should be recorded on the ASP6.

If as a result of information received at referral or from the Strategy Discussion, significant concerns emerge regarding very serious risk of harm or homicide from domestic violence, the Designated Officer should consider whether referral to the Multi Agency Risk Assessment Conference (MARAC) might be appropriate.

## **2.5 Multi-Agency Risk Assessment Conference (MARAC)**

It should be noted that the main aim of the MARAC is to reduce the risk of serious harm by providing a forum for a co-ordinated Multi-Agency response to Protection Planning for the victims of domestic violence.

Each Service Group will have appointed a named MARAC Representative and all cases being considered under MARAC should be discussed and agreed with the Service Group MARAC Representative to establish whether the criteria for referral is met.

A specific Risk Identification Checklist (CADDA-DASH-NI) should be used in all cases of alleged or suspected domestic violence/abuse to determine whether a referral to MARAC is appropriate (see Appendix 5).

The threshold to referral to MARAC is one or a combination of the following:

- score 14 or more on the DASH form
- professional judgement
- Escalation of incidents, three or more police call outs in a twelve month period or an increase in the severity of abuse

Were a referral to MARAC is considered appropriate the consent of the vulnerable adult should be sought. In exceptional circumstances of serious risk of harm consideration may need to be given to referral without consent. A clear rationale for this decision should be recorded which reflects Human Rights considerations.

The legal grounds for sharing information without consent are covered under the Data Protection Act and the Human Rights Act (Art 2+3)

If a referral is considered appropriate, a MARAC referral form should be completed and forwarded to the Trust MARAC Representative for the service group and also the nominated PSNI MARAC Representative.

### Role of nominated Trust MARAC representative for each service group.

Potential new referrals from within Trust service groups to MARAC should be forwarded to the Trust MARAC representative who will:

1. Review DASH and MARAC referral form in order to establish whether referral to MARAC is appropriate
2. Consider issues of Consent & Capacity
3. Refer to MARAC if appropriate
4. Attend MARAC meetings to present information and contribute to action plans.



Cases listed for MARAC

Review cases listed for MARAC meetings. Collate information and attend MARAC meetings as appropriate where the:

- Individual is known to service group - collate relevant information, consider issues of consent, capacity and data protection
- Individual not known to service group but information indicates that they fall within what would normally be considered the programme of care, i.e. victim is over 65 years old - Older Peoples programme of care.

Trust nominated MARAC representatives and those attending MARAC meetings should ensure that they have a detailed understanding of the MARAC process and the roles and responsibilities within this. It is therefore recommended that representatives read the MARAC Operating Protocol and the MARAC Information Sharing Agreement.

It must be stressed that MARAC offers an additional mechanism/forum to look at protection arrangements for a small number of vulnerable adults at very serious risk of harm but does not replace the need for protection and investigation under Adult Protection Procedures. In Adult Protection cases where a MARAC referral is deemed to be appropriate, MARAC should be used to enhance the protection planning process.

**2.6 Joint Protocol Considerations**

Following the Strategy Discussion and depending on the decisions made, the investigation may proceed through a single agency investigation, joint investigation with PSNI or joint investigation with other agencies.

- (a) Single Agency Investigations. These are investigations where intervention rests solely with one agency, e.g. Trust, PSNI.
- (b) Joint Investigations with the Police. A detailed consideration of the need for a joint investigation with the PSNI will be triggered when there is an allegation or suspicion that one of the following criminal offences has been committed against a vulnerable adult:
  - A sexual offence committed against a vulnerable adult. Allegations or suspected sexual abuse
  - Physical abuse or ill-treatment amounting to a criminal offence
  - Financial abuse involving a criminal offence such as fraud or theft
  - Abuse which involves a criminal offence; e.g. blackmail.

Allegations should be reported to either the PSNI Rape Crime Unit/SARC

Allegations should be reported to the appropriate PSNI Crime Unit.

Where a decision to proceed to joint investigation is taken, the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009 must be followed.

Under this Protocol the Designated Officer should decide whether the grounds for Joint Agency Consultation are met. The Designated Officer should, if they suspect a crime has been committed, contact PSNI within 24 hours. As the referrer, the Designated Officer has a responsibility to complete the AJP1 form, which is a record of the Joint Agency Consultation. The Designated Officer must send the original AJP1 to the PSNI and retain a copy on the client file.

All Designated Officers and staff trained in ABE should use the Criminal Justice secure Messaging Service (CJSM) to facilitate communication (see Appendix 6).

In instances of abuse that constitute a criminal offence and where there is a decision that the Trust and PSNI will jointly investigate the incident, it must be remembered that only staff trained as Specialist Interviewers should conduct Achieving Best Evidence interviews.

Staff conducting interviews under ABE must comply fully with the requirements and processes as detailed in the Achieving Best Evidence in Criminal Proceedings January 2012.

- (c) Joint Investigations with Other Agencies. These are investigations which involve more than one agency or organisation but which lie outside the 'Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults', e.g. Joint Investigations between Trust and Care Provider

Where the vulnerable adult receives a service from a registered establishment or agency (statutory, private and independent sector), the manager of the registered facility has a responsibility to inform RQIA of any ongoing investigation. The Designated Officer must also refer the matter immediately to the appropriate Inspector within RQIA, in keeping with RQIA Reporting Procedures.

Where care is being purchased by the BHSCT outside of the Trust area, the Care Provider must notify the relevant BHSCT staff of any allegations or suspicions of abuse and they in turn must notify the relevant Trust Designated Officer. For Older people and Physical Health and Sensory Disability Services the Adult Safeguarding Gateway team Care must be notified.

Close communication and co-ordination should take place between the relevant Designated Officer within the Belfast Trust (Commissioning Trust) and the relevant Designated Officer in the host Trust. The Belfast Trust, as the Commissioning Trust, will take the lead role in relation to their individual client, however if there is a wider protection issue the host Trust will take the lead role and involve the commissioning Trust as part of this process.

Where care is being purchased within the BHSCT by another Trust and an individual case of suspected, alleged or confirmed abuse occurs, the commissioning Trust will be responsible for investigation and protection planning in relation to their client. In cases where a wider protection issue has been identified, the host Trust will take the lead role in terms of co-ordination and overall management of the investigation.

For Older people and Physical Health and Sensory Disability Services the Adult Safeguarding Gateway team Care will take the lead role.

The relevant Designated Officer will work in partnership with the relevant Care Provider to ensure that a full investigation is carried out and that Adult Protection Policy & Procedures are adhered to (*see section 1.9 for more details regarding joint investigation between Trust and other agencies / providers*).

## **STAGE 4**

### **2.7 Investigation / Risk Assessment**

The Investigating Officer will take the lead role in carrying out the investigation and must keep the Designated Officer fully informed throughout the investigation process. The purpose of the investigation is to establish the facts and contributing factors leading to the referral. In addition there are responsibilities to identify and manage risk to ensure the safety of the individual and others. It should seek to clarify the views of the vulnerable adult, facilitate a mental capacity assessment if required and where necessary appoint an advocate to act in the best needs of the vulnerable adult.

The Investigating Officer should ensure that the alleged victim is interviewed if appropriate and is fully involved in all decisions at all stages in the investigation process. In situations where this is not possible, i.e. significant cognitive impairment or severe learning disability, a carer, family member or advocate should be involved if appropriate. Interviews with the alleged victim and significant others should be recorded on the ASP3.

Careful consideration should be given to whether an alleged perpetrator will be interviewed. Staff should be mindful of the potential for aggression or violence. The Belfast Trust Policy 'A Zero Tolerance Approach to the Prevention and Management of Violence and Aggression in the Workplace 2008' is applicable. In certain circumstances to ensure the protection of staff, a range of measures will be looked at, i.e. two staff members being involved in interviews, venue of interviews, etc.

The Investigating Officer is required to carry out a Risk Assessment as part of the investigation and must complete the ASP4 or a Risk Assessment form which has been approved by their service group as suitable for Adult Protection Risk Assessment purposes. Due consideration must be given to issues of Human Rights and recorded on the ASP4. If a human rights issue has been identified the ASP7 Human Rights form may also need to be completed.

In situations where the alleged perpetrator is also a vulnerable adult, referral on to another programme of care may be appropriate. If the alleged perpetrator is already known to another programme of care, close communication and co-ordination should take place to ensure that the needs of both clients are fully met.

**STAGE 5****2.8 Protection Planning / Monitoring / Review**

The vulnerable adult should be fully involved in the drawing up of the protection plan and where this is not possible a family member, carer or advocate should be involved if appropriate. The protection plan should be recorded on the ASP5.

The vulnerable adult and/or carer/family (if appropriate) and relevant others should be provided with the protection plan within three working days of it being agreed.

Consideration of whether the abuse constitutes a very serious risk of harm due to domestic violence should be kept under close review and referral to MARAC can be considered at any stage of the investigation if the referral criteria for MARAC is met (see section 2.5 MARAC)

In cases deemed to be of continued high risk, the situation should be closely monitored and the protection plan reviewed by the Investigating Officer and Designated Officer within 24 hours, or as required. The ASP8 form should be completed.

In all other cases the protection plan should be reviewed with the vulnerable adult and/or relevant others within 10 days of implementation by the Investigating Officer. The ASP8 should be completed.

Ongoing protection plans should then be reviewed at three-monthly intervals (minimum) by the Investigating Officer and ASP8 completed. If there are significant concerns that the protection plan is not effectively addressing the risks, the Designated Officer may formally review the protection plan as part of a Case Conference. An ASP6 form must be completed as a Minute of the Case Review meeting.

**STAGE 6****2.9 Decision Making****Strategy Meeting/Case Conference /Case Discussions /Family Meeting**

A Strategy Meeting/Case Discussion/Case Conference/Family meeting can be convened where appropriate at any stage throughout the process. The purpose of these meetings are to identify risks and the actions necessary to manage these risks. Any interim protection plan should be reviewed and an appropriate protection plan must be agreed at these meetings.

Were the Designated Officer has concerns in relation to the protection plan and/or the process of the investigation these should be raised directly with the relevant parties in the first instance. Were an issue is unresolved the Designated Officer should raise this with their own line management/Senior Management. In exceptional circumstances the Designated Officer can contact the Trust wide Adult Safeguarding Lead and /or the Social Work Governance Manager.

Where there are ongoing serious risks within a case, a case conference should be convened and chaired by the Designated Officer as soon as possible and no later than 14 days after the completion of the investigation.

A minute of the Case Conference/Case Discussion should be taken and recorded on an ASP6. An ASP7 Human Rights form must also be completed as part of the decision making process.

## **STAGE 7**

### **2.10 Transfer/Closure**

Decisions regarding transfer or closure of a case under the Adult Protection Procedures must be made in consultation with the vulnerable adult if appropriate and all relevant others. An ASP9 form should be completed.

The Designated Officer is responsible for ensuring that appropriate information is provided to the receiving service to allow for the ongoing monitoring and protection of the vulnerable adult.

The Designated Officer is responsible for ensuring that the Adult Safeguarding Alert is amended as follows '**Adult Safeguarding previous involvement**' with contact name and telephone number.

**SECTION 3****3.1 Investigations in relation to Hospital Setting (Accident & Emergency / Hospital In-patients)**

*(See Appendix 7 Flow Chart which details reporting arrangements)*

**Roles of all hospital staff**

- All hospital staff (doctors, nurses, radiographer, cleaners, etc.) should be alert to the possibility of abuse of vulnerable adults.
- Any concerns staff have should be reported immediately to their line manager, i.e. Ward Sister, Consultant, etc. Staff have a duty of care to report alleged, suspected or confirmed abuse and staff who fail to report concerns regarding abuse could be subject to Trust disciplinary procedures and sanctioned by their professional body, such as Nursing & Midwifery or NISCC.
- The line manager/ward manager will decide if any actions need to be taken and should consult immediately with the Hospital Designated Officer or the EDT Designated Officer if the concern is raised out of hours and there are immediate risks to be addressed or a report to the PSNI is required. It is recommended that the line manager/ward manager consults with the Hospital Designated Officer/Senior Social Worker if they are in any doubt as to whether an issue falls within the scope of the Adult Protection Policy.
- The line manager/ward manager should inform and seek guidance and direction from the appropriate Assistant Service Manager/Senior Manager when the incident occurs within the hospital or relates to a staff member. If the concern is raised out of normal office hours contact should be made with Senior Manager on Site/Senior Manager on Call
- The Senior Manager on Site/Senior Manager on Call should assess available information and consult with the Hospital/EDT Designated Officer to determine whether the situation falls under the Adult Protection Policy & Procedure. It is the responsibility of the Senior Manager on site to ensure that an interim protection plan is in place to support and protect the vulnerable adult
- In all cases where hospital discharge is imminent and significant risks to the individual have been identified an urgent Adult Safeguarding discussion/meeting should take place to ensure the protection of the vulnerable adult

**Role of Designated Officer**

- The Hospital Designated Officer should record all information provided via telephone referrals on an ASP1 Section 1.
- The hospital Designated Officer will review available information in conjunction with the referrer and will make the decision as to whether further investigation under the Adult Protection Policy is required.(See Stage 2)

- In all cases of alleged, suspected or confirmed abuse when a crime is suspected the Protocol for Joint Investigating of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009) must be strictly adhered to. Through the Joint Agency Consultation Process a decision will be made as to who is best placed to take forward a vulnerable adult investigation.
- The hospital Designated Officer will establish the patient/vulnerable adult's area of residence and consult with relevant Trust.

#### Belfast Trust

Older People and PHSD Services- consult with the Adult Safeguarding Gateway Team

Learning Disability and Mental Health Services- consult with the relevant Designated Officer

#### Other Trusts

Continue with existing arrangements.

- In situations where the Belfast Trust is conducting the investigation and the abuse relates to an incident occurring within a hospital setting, the hospital Designated Officer will immediately link with the relevant Designated Officer and consideration will be given to who is best placed to take on the management responsibility for the investigation.
- If the allegation is disclosed in hospital but is alleged to have occurred in a regulated care facility (Residential, Nursing, EMI, Statutory, Voluntary), the hospital Designated Officer should notify the relevant Trust, the care facility and RQIA of the allegation. Adult Protection and RQIA procedures must be followed.
- Where the concern or allegation relates to a vulnerable adult known to Mental Health Service or Learning Disability Programme of Care, the hospital Designated Officer should inform RQIA when an investigation is initiated and also of the eventual outcome.
- Protection measures must be in place to protect the vulnerable adult
  - If there are risks to the vulnerable adult within the hospital setting it is the responsibility of the relevant hospital staff to provide an appropriate protection plan. The Hospital Designated Officer should be satisfied that the protection plan is addressing the risks
  - If there are risks to the vulnerable adult within a regulated facility or within the community the hospital staff and the relevant Designated Officers should work together to ensure that an appropriate protection plan is in place prior to discharge.

## Immediate Concerns

If there is an immediate concern for the safety and well being of a patient because of an incident which has occurred on the hospital site, the line manager/ward manager should immediately:

- Ensure that the patient is in no imminent danger and that he/she is protected from harm and his/her needs are being met, i.e. Hospital Security and/or PSNI may be required
- Refer to the hospital Designated Officer who will then screen the referral and decide on whether the Adult Protection Procedures are applicable and what further action is required. If out of office hours contact should be made with the Emergency Duty Team Designated Officer
- Inform and seek guidance and direction from the appropriate Assistant Service Manager/Senior Manager. If out of office hours contact should be made with Senior Manager on Site/Senior Manager on Call
- The Senior Manager on Site/Senior Manager on Call should assess available information and consult with the hospital/EDT Designated Officer to determine whether the situation falls under the Adult Protection Policy & Procedure.
- It is the responsibility of the Senior Manager on Site to ensure that an interim protection plan is in place to support and protect the vulnerable adult.
- The role of the Emergency Duty Team in such cases will be to provide access to a Designated Officer who will:
  - ensure that the interim protection plan effectively addresses any immediate risk to the vulnerable adult
  - assist and advise the Senior Manager in managing the situation
- It is recognised that EDT, as an Out-of-Hours Service, only priority issues will be addressed i.e. consideration must be given to whether PSNI need to be involved. If crime is suspected there should be no delay in reporting concerns to PSNI. It should be remembered that vulnerable adults may require assistance when being interviewed by the Police. The Emergency Duty Team will facilitate access to a Specialist Interviewer if PSNI wish to conduct an interview
- It is the responsibility of the EDT Designated Officer to ensure that Adult Protection cases arising out of hours are reported to the relevant Designated Officer as soon as possible on the first working day.

The EDT ASP form should be forwarded to:

- Older People and Physical Health and Sensory Disability Services- Adult Safeguarding Team Duty Desk
- Learning Disability and Mental Health Services-Case holder/Duty Officer of local team and copy to relevant Designated Officer.



### 3.2 Investigations in relation to Regulated Services

(See Appendix 8 - Flow Chart which details reporting arrangements)

Regulated services include; (Trust and Independent Sectors)

- Domiciliary Care
- Day Centres
- Residential Care Facilities
- Nursing Home Facilities
- Supported Housing
- Hospital Settings

In all cases of alleged or suspected abuse of a vulnerable adult in a regulated service there is a need for close communication between the key professionals involved which may include the Trust Care Management/Commissioner of service , Quality Assurance Team, Registered Manager/Registered Provider, relevant Hospital staff, Trust Designated Officer and RQIA. Where a crime is suspected and the Protocol for Joint Investigation may be appropriate, PSNI will need to be consulted. It is therefore a requirement that all key professionals attend strategy meetings, case reviews and case conferences.

#### Role of Commissioner of service (Care Management, Social Work)

- Commissioners of service have the clear responsibility to ensure that the services commissioned meet the assessed needs of the individual and are compliant with the requirements as set out in the Service Level agreement.
- Breaches in any requirements should result in notification to Line Management and the Quality Assurance/Monitoring Team.
- In the context of Adult Safeguarding these responsibilities also include the need to be alert to and report any alleged, suspected or confirmed abuse in relation to both care facilities and domiciliary providers to the Trust Adult Safeguarding Gateway Team in relation to Older People and Physical Health and Sensory Disability Services and in Learning Disability and Mental Health Services to the relevant Designated Officer. Form ASP1 should be completed by the referrer when referring under Adult protection Procedures
- Form ASP1 should be completed by the referrer and consultation with the line manager must take place when considering a referral under Adult Protection Procedures
- To contribute to an Adult Protection investigation and protection plans as directed by the Trust Designated Officer. This may include providing information, attending Adult Protection meetings and conducting wider screening interviews.

### Role of Quantity Assurance Team (QAT) in Older People and Physical Health and Sensory Disability Services in relation to Adult Safeguarding

- In individual cases where the QAT receives a report which may constitute an adult safeguarding issue, a consultation should take place with the Designated Officer in the Adult Safeguarding Gateway Team
- Where the QAT identify a pattern or trend of recurring poor practice issues/ quality of care issues in relation to the same care facility or domiciliary provider, discussion should take place with the Designated Officer in the Adult Safeguarding Gateway Team to determine if there is an institutional abuse issue
- Co-ordinating the collation of data in relation to adverse incidents, complaints, quality issues and compliments
- Preparing a quarterly report on incidents/complaints for tabling at governance committee
- To collate and provide information for the annual contract meetings with the domiciliary providers and quality assure the contract in relation to domiciliary commissioned services
- Regular meetings should take place between the QAT and the Adult Safeguarding Gateway Team Manager to review all care facility and domiciliary provider issues to:
  - identify patterns and trends in relation to individual regulated services
  - to identify areas of concerns which need to be addressed
  - to determine if actions are required and who will take responsibility for these

### Role and Responsibility of Registered Managers in Regulated Services

The Registered Manager must ensure that:

- Their service is compliant with the Safeguarding Vulnerable Groups Order (N.I) 2007 Vetting and Barring Scheme, as amended by The Protection of Freedoms Act 2012 and ensure that future legislative changes are implemented where applicable
- Adult Protection Policies and Procedures are in place which are consistent with Regional and Trust Adult Protection requirements
- All staff receives appropriate training in relation to adult protection and that refresher training is provided in keeping with regulatory requirements
- There is a clear and explicit reporting mechanism in place to respond to allegations of alleged, suspected or confirmed abuse
- A Whistle Blowing Policy is in place which supports staff in raising any issues
- Reporting arrangements are in place within the service that require all staff to report any concerns to senior staff and the registered manager
- Any alleged, suspected or confirmed abuse of a vulnerable adult is reported to a Trust Designated Officer, the case holder and RQIA immediately or on the first working day

- Any internal investigation should not be commenced without consultation with the Trust Designated Officer and/or PSNI. This includes any interviews with service users or staff
- Staff are fully aware of their responsibilities to contribute to any investigation (Adult Protection, Disciplinary, Criminal or Professional Body) by providing statements and if necessary giving evidence
- When a crime is suspected, where appropriate, a report should be made to the PSNI in keeping with the requirements of the Joint Protocol and any possible forensic evidence is secured
- The safety and wellbeing of the vulnerable adult is given priority by the service provider and that there is clear and explicit responsibility to ensure that a robust interim protection plan is in place to address their immediate protection needs
- Where other vulnerable adults may be at risk and the interim protection plan also should ensure their protection
- Details of the interim protection plan should be provided to the Trust Designated Officer at the time of reporting the allegation or suspicion of abuse
- In situations where the Trust Designated Officer expresses concern that the interim protection plan may not meet the protection needs of the vulnerable adult or others who are at risk, it is the responsibility of the Registered Manager to review the protection plan accordingly
- Where allegations relate to a staff member it will be the responsibility of the registered manager to consider whether investigation under Disciplinary Procedures is appropriate. Due consideration needs to be given to the interface between Adult Protection and Disciplinary Procedures
- Procedures in relation to reporting to the Independent Safeguarding Authority and any other relevant professional bodies should be followed if applicable. The registered manager as the employer is responsible for providing any information or reports required
- If Trust Designated Officer decides that wider screening interviews with other service users and/or staff are required as part of the adult protection, it is the registered manager's responsibility to provide the necessary information and contribute to the investigation as directed by the Trust Designated Officer
- On completion of the adult protection investigation the registered manager should provide a written report of the outcome to RQIA and forward a copy to Trust Designated Officer.

#### Role and Regulation, Quality & Improvement Authority (RQIA)

- To report any concerns regarding alleged or suspected abuse of a vulnerable adult to a relevant Trust Designated Officer and /or PSNI if appropriate
- To monitor and inspect regulated services to ensure all regulatory requirements in relation to alleged or suspected abuse of a vulnerable adult are complied with. This will include ensuring that Vulnerable Adult Policies and Procedures are complied with.
- Consider information in the context of regulatory requirements and take a lead role when regulatory requirements are breached, i.e. institutional abuse cases.

- To contribute to Adult Protection investigations and protection plans through attendance at meetings and where appropriate provide relevant information and input into any action plans.

### Role of Trust Designated Officer and Investigation Officers

The Trust Designated Officer is responsible for the overall co-ordination of the Adult Protection Investigation and protection plan including the convening and chairing of Adult Protection meetings

*(For details in relation to Adult Protection process see Appendix 2)*

### **3.3 Vulnerable Adult Investigations when an allegation is made against Staff Member(s)**

The Trust is required to ensure that, in situations where an allegation of alleged, suspected or confirmed abuse of a vulnerable adult by a member of staff is made, appropriate processes are in place to effectively address the needs of the vulnerable adult and the rights of the employees.

Staff have a right and a duty to raise concerns with the Trust and the Trust expects staff to follow existing reporting procedures. In situations where staff have concerns that the existing reporting procedures have not effectively address the issue raised, the Trust Whistle Blowing Policy may be applicable.

The Trust Whistle Blowing Policy clearly sets out the Trust commitment to support staff that raise concerns (Public Interest Disclosure Order NI 1998).

The following existing processes need to be considered when an allegation is made against staff member(s):

- A.** The interface between the Adult Protection Procedure and Disciplinary Procedure
- B.** Where allegations made against a staff member constitutes a possible crime, The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009) should be applied
- C.** Reporting to the Independent Safeguarding Authority and relevant professional bodies, e.g. NISCC, NMC etc. (see Choosing to Protect Guidelines, DHSSPS 2008; Safeguarding Vulnerable Groups NI Order 2007 and Trust Procedures to be followed)
- D.** Reporting arrangements in relation to Regulated Facilities

Service Providers Commissioned by the Trust is required to have in place similar procedures which reflect Trust processes.

## A. The interface between the Adult Protection Procedure and the Disciplinary Procedure

- Any complaints or concerns from any source in relation to a staff member which constitutes an adult protection issue should be reported to the relevant line manager immediately
- Any allegations of alleged or suspected abuse of a vulnerable adult by a staff member should be reported immediately to the staff member's line manager or within regulated services, to the registered manager.
- The line manager/registered manager must immediately report any allegations of alleged suspected or confirmed abuse of a vulnerable adult by staff members to the relevant senior manager/duty senior manager for the service group.
- Trust Disciplinary Procedures **may** need to be considered and consultation with Human Resources should take place where appropriate. (Employment Law/Employee Relations section).
- The line manager/registered manager, having been made aware of an allegation against a staff member, must also immediately report the referral to the relevant Trust Designated Officer.
- It is the line manager's responsibility to ensure that any telephone referral is followed by the completion of the ASP1 form and forwarded to the Designated Officer within two working days
- The Designated Officer will assess the information provided by line manager/registered manager and decide whether the Adult Protection Procedures apply and/or whether the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009) needs to be considered. During this initial screening process the protection of the vulnerable adult(s) must be discussed.
- It is the responsibility of the line manager/registered manager (Trust /Commissioned Service Provider) to ensure the immediate protection of the vulnerable adult(s).
- It is the responsibility of the line manager/registered manager to provide the Designated Officer with details of interim protection plan. In most situations it is anticipated that this will be agreed on the day of referral and will take immediate effect
- Actions taken in relation to the named staff are decisions for which the staff members line management are responsible and accountable.(Trust or/Commissioned Service Provider)
- Any actions taken by the line manager/registered manager need to consider the protection and rights of the vulnerable adult/s balanced with the rights of the staff.

- A range of options may need to be considered by the line manager/registered manager and in some situations may include placing the staff member/s in an alternative position on temporary basis or on precautionary suspension
- If the Designated Officer is concerned that the interim protection plan does not afford the vulnerable adult adequate protection he/she should raise this in the first instance with the line manager/registered manager. Trust line manager/registered manager should consult with senior management and Human Resources regarding staffing issues associated with protection arrangements
- In exceptional circumstances if agreement is not reached between the Designated Officer and line manager/registered manager it is the responsibility of both the Designated Officer and line manager/registered manager to inform RQIA
- In most situations, interviews with the staff member whom the allegation has been made against will be conducted by the staff member's line management/senior management in consultation with Human Resources. At the Strategy planning stage, if a decision is made to interview staff as part of the Adult Safeguarding investigation, the person nominated to interview the staff member/s will ensure the following information is provided:  
If the staff member against whom the allegation has been made is to be interviewed it is important that the staff member is informed/reminded that he/she has a right to have colleague or trade union representation present at any interview. If wider screening interviews with staff are to take place, staff members should also be informed/reminded that he/she has a right to have colleague or trade union representation present at any interview.

***Addendum to Belfast Health and Social Care Trust Adult Protection Policy & Procedures 2013 - Section 3.3 Vulnerable Adult Investigations when an allegation is made against Staff Member(s)***

- It will be the responsibility of the line manager/registered manager to inform their staff member of the allegation and what measures are to be taken i.e. whether an investigation under Adult Protection Procedure and/or whether the allegation will be managed under Disciplinary Procedures.
- The Adult Protection and Disciplinary investigations will be conducted separately and will be undertaken by two separate appointed representatives.
- The Adult Protection investigation will be conducted in keeping with the Trust Adult Protection Procedures and the Designated Officer will appoint an Investigating Officer.
- The disciplinary investigation will be conducted in keeping with the Trust Disciplinary Procedures and the Senior Management will nominate a Trust Officer to carry out this investigation.
- Decisions regarding the planning and timing of these two investigative processes will be determined on a case by case basis and will be agreed by the Designated Officer, line manager/registered manager in consultation with their Senior Manager and Human Resources.

- In complex cases it may be necessary to have an internal Trust Strategy meeting/s to agree the detail of how the interface between Adult Protection procedures and Disciplinary procedures. In these situations it is anticipated that a Senior Manager Level 4 or above will chair these meetings.
- There are a number of possible options in relation to the detail of how these investigations can proceed and these options should be considered at the initial Adult Protection Strategy Meeting. In complex cases a Senior Manager may need to be included to assist with the detailed planning in relation to the investigation strategy. Possible options for consideration can include:
  1. The Adult Protection and the Disciplinary investigations will be conducted totally separately
  2. The two investigations can be conducted separately with relevant information shared on a need to know basis:
    - Where an Adult Safeguarding investigation is being conducted and staff interviews are to take place it is the relevant line manager's responsibility to coordinate the interviews
    - The line manager should also ensure that staff are advised that relevant information may need to be shared within any of the investigative processes. In situations where information from an Adult Safeguarding investigation is relevant to either a disciplinary or police investigation consent should be sought for the sharing of this information from the vulnerable adult and/or others
  3. The Designated Officer and Trust nominated representative can, if agreed conduct joint interviews with the staff member under investigation and/or other relevant staff members.

**B. Where allegations made against a staff member constitutes a possible crime, the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009) should be applied**

In situations where an allegation of abuse is made against a staff member in relation to a vulnerable adult which constitutes a possible crime, the Trust and other services commissioned by the Trust should consider whether consultation with the PSNI is required. In such circumstances The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009) should be applied.

Line manager/registered manager must immediately report any allegations of alleged suspected or confirmed abuse of a vulnerable adult by staff members to:

- The relevant Senior Manager/Duty Senior Manager for the service group.
- The relevant Designated Officer or Emergency Duty Team Designated Officer.
- In situations where the vulnerable adult is considered to be in imminent danger and in need of immediate protection the line manager/registered manager should

take whatever action necessary to protect the vulnerable adult including medical assistance.

- In situations where there is significant concern that a serious crime has been committed there should be no delay in contacting the PSNI who will determine whether a criminal investigation is appropriate.
- In situations where the allegation relates to potential financial abuse a report should be made to the Trust Fraud section within the Finance Department for information and where appropriate for advice.
- In all other situations the Designated Officer will assess the information and determine whether a consultation/report to the PSNI is required. The Designated Officer will also determine, based on available information whether there is any immediate action is required to ensure the protection of the vulnerable adult and liaise with the line manager/registered manager in relation to this.
- Protection of the vulnerable adult(s) will always take precedence and any actions required under adult safeguarding to ensure protection should not be delayed by a PSNI investigation. However any actions planned should where possible be discussed with the PSNI in advance to agree a way forward.
- A Strategy Meeting/Discussion under Joint Protocol will take place to determine roles and responsibilities and agree the immediate action plan.
- Where an Adult Safeguarding investigation relates to a Trust service, a Trust internal management meeting may also be required to manage the interface between Adult Safeguarding, Disciplinary and PSNI investigations. This meeting should be chaired by a Senior Manager (Level 4 or above) and should include the Designated Officer and line manager. Where such a meeting is convened, consideration should also be given to involving colleagues from Human Resources, Employment Law and the relevant Corporate Team (for example Corporate Nursing). It should be noted that these meetings are additional to and do not replace the Trust Adult Safeguarding Procedures.
- In these cases a Trust representative should be nominated to liaise with the PSNI on an ongoing basis in relation to the progress of the criminal investigation as it pertains to the staff member.
- In situations where a criminal investigation under Joint Protocol arrangements takes place the adult safeguarding investigation and possible disciplinary investigation should take cognisance of the Police investigation.
- Full discussion with PSNI should take place before the Trust undertakes interviews with staff in relation to the allegation. Line management should be mindful that interviewing staff in advance of a consultation with the PSNI could jeopardise a police investigation.



- In most situations a disciplinary investigation will only commence when the PSNI investigation is concluded or after PSNI interviews with relevant staff have been conducted.
- In situations where precautionary suspension is required due to the nature of the alleged offence or is a requirement of a protection plan, Trust Disciplinary procedures in relation to meeting with the staff member/members should be followed.  
However consultation with the PSNI may be required in relation to the level of information given to the staff member where a criminal investigation is underway to ensure any criminal investigation is not compromised.
- Staff reporting concerns regarding alleged, suspected or confirmed abuse will be expected to contribute fully to any investigative process including Adult Protection, Disciplinary or PSNI investigation
- The criteria and threshold for PSNI investigation, Adult Protection investigation and Disciplinary investigation differ. Staffs are reminded that the burden of proof in criminal cases is higher, therefore where a PSNI investigation has taken place and the threshold for criminal prosecution has not been met, an Adult protection investigation should be considered and the Disciplinary Investigation should be concluded.

**C. Reporting to the Independent Safeguarding Authority and relevant professional bodies e.g. NISCC, NMC, etc. (see Choosing to Protect guidelines, DHSSPS 2008)**

- The line manager/registered manager and senior management should consider whether the criteria for referral of the staff member to ISA and /or relevant professional bodies are met.
- The Senior Service Manager is then responsible to ensure that a referral is made to the appropriate body/s. Within the Trust, Human Resources will take the lead role in reporting to the Independent Safeguarding Authority and the relevant Senior Professional lead is responsible for the referral to the professional body after consultation with senior management.
- It is the responsibility of the staff member's line manager to provide information at the time of reporting and respond to any subsequent requests for information. Commissioned Service Providers must ensure that their agencies comply with this requirement.

## D. Reporting arrangements in relation to Regulated Facilities

In keeping with RQIA regulations, the Registered Manager must report and complete an RQIA incident report form. A copy of the incident report should also be forwarded to the Designated Officer, Quality Assurance Team, and case holder.

### 3.4 Trust Protocol for responding to cases of alleged, suspected or confirmed abuse where the adult victim does not match programme of care definitions (Service Area)

- The Trust is committed to the principle of ensuring that all adults who are subject to alleged, suspected or confirmed abuse will receive a sensitive, supportive and appropriate response from the Trust
- The Trust recognises that in some situations it will not always be clear from the outset which programme of care should be responding to an allegation of abuse. In other situations the abuse referral may not match neatly with any of the Trust programme of care (service area) definitions. In these circumstances where there is a lack of clarity regarding which programme of care is best placed to respond, the programme of care receiving the referral should:
  - Try to gather as much detail as possible from referrer in order to identify who is best placed to respond to the adult in need of protection
  - In some situations advice and/or referral on to another agency such as Women's Aid may be appropriate. In such circumstances the receiver of the referral should provide the assistance required
  - Where referral details indicate a need for immediate assistance there should be no delay in response, so the programme of care receiving the referral should take whatever immediate actions are required to protect the adult.
- In determining who is best placed to respond to a referral, the focus should be on the needs of the adult. Any pre-existing eligibility criteria normally viewed as a prerequisite to receiving support services from a specific programme of care (service area) will not prevent an AS investigation and the provision of support to a vulnerable adult.

As a general rule where the referral information indicates that:

1. The adult victim is over 65 years old or is under 65 years old and has a physical or sensory disability, the referral should be directed to the AS Gateway Team
2. The adult victim is under 65 years old and may have a mental health issue, irrespective of whether this constitutes a treatable, diagnosed condition, the referral should be directed to Mental Health Service for initial screening
3. Where the adult victim may have a low IQ irrespective of whether their IQ has been assessed or meets current service area threshold, this should be directed to Learning Disability Services for initial screening.

In cases where there is a dispute regarding which programme of care is best placed to deal with the referral, the referral should be brought to the attention of the

Assistant Service Manager/Operational Manager for the service who received the referral.

- The Assistant Service Manager will review available information and determine whether their service will deal with the referral or whether he/she should discuss referral with a Service Manager from another programme of care.
- Decisions regarding allocation of cases should be made within 24 hours or earlier, depending on the nature and level of risk identified in the referral.
- A record of cases referred which do not match any programme of care should be recorded on the monthly AS statistical returns to TASS, along with details of which programme of care received the referral and which programme of care dealt with the referral.
- In the unlikely event that the Assistant Service Manager/Operational Manager cannot reach an agreement with regard to who is best placed to deal with a referral, consideration will be given to the statistical record to ensure equitable allocation of workload.

### **3.5 Direct Payments**

Where a Direct Payment is in place, clients and their carers should be made aware of the arrangements for the management of adult protection in their area. Such service users should receive the same level of support and protection as any other vulnerable adult if abuse occurs. Any concerns should be reported in the first instance to the Trust representative, i.e. Care Manager, Social Worker, who in turn will link with the relevant service group to initiate Adult Protection procedures.

# APPENDICES

## Appendix 1

### Consent/Capacity/Human Rights

**Consent / Capacity / Human Rights**

*(Extract from Safeguarding Vulnerable Adults Regional Adult Protection Policy & Procedural Guidance 2006)*

Consent, Capacity and Human Rights must be considered in all decision making processes at every stage of an adult protection investigation and due consideration given to concepts of proportionality and equality of arms.

**Consent /Capacity**

**8.1** One of the key challenges in relation to work with vulnerable adults relates to capacity and consent in considering what action should be taken about alleged or suspected abuse. Two key questions need to be addressed:

- (i) did the vulnerable adult give meaningful consent to the act, relationship or situation which constitutes the alleged or suspected abuse?
- (ii) does the person now give meaningful consent to any preventable action, investigation or report to the PSNI?

**8.2** It is also necessary to determine both whether the person could consent and whether they did consent. Abuse may occur when any of the following conditions apply:

- the person does not consent;
- the person is unable to consent, either because of issues of capacity or because the law does not permit the vulnerable adult to give consent to a particular act or relationship;
- other barriers to consent exist for the vulnerable adult; e.g. where the person may be experiencing intimidation or coercion.

**8.3** The principles contained in Good Practice in Consent (DHSSPS, 2003) and enshrined in the legislation relating to mental incapacity which have been enacted in England and Wales<sup>6</sup>, offer some useful guidelines for determining individual capacity and ability to consent. These include:

- a person must be assumed to have capacity unless it is clearly established that this is not so;
- a person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success;
- a person should not be considered as being unable to make a decision merely because he makes an unwise decision;
- an act done or decision made under this legislation for, or on behalf of, the person who lacks capacity, must be done, or made, in his best interests;
- before any action is taken, or decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and

freedom of action.

**8.4** Under this legislation a person is deemed to lack capacity in a matter if, at the same time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary. A person is deemed unable to make a decision for himself if he cannot:

- understand the information relevant to the decision;
- retain that information;
- use or weigh-up that information as part of the process of making that decision;
- communicate his decision (by speech, gesture, signing or any other means).

**8.5** Where a person is deemed unable to make a decision every reasonable and practicable effort must be made to encourage and permit the person to participate, or to improve his ability to do so as fully as possible in any act done for him and decision affecting him. If it is decided that an adult does not have capacity, then staff should act in a way which is in that person's best interests; i.e. what is necessary to promote health or wellbeing or prevent deterioration, consistent with existing legislation.

### Human Rights

The Human Rights Act 1998 is an Act of the Westminster Parliament which makes the European Convention on Human Rights part of the law of all parts of the United Kingdom. Although passed in 1998, the Human Rights Act did not fully come into effect until 2nd October 2000.

In making the European Convention part of the law of Northern Ireland, the Human Rights Act allows individuals and organisations to go to Court, or to a tribunal to, seek a remedy if they believe that the rights conferred on them by the European Convention have been violated by a public authority .

These principles assume that vulnerable adults have the right to:

- be accorded the same respect and dignity as any other adult, by recognising their uniqueness and personal needs;
- be given access to knowledge and information which they can understand to help them make informed choices;
- information about, and practical help in, keeping themselves safe and protecting themselves from abuse;
- live safely, without fear of violence or abuse in any form;
- have their money, goods and possessions treated with respect, and to receive equal protection for themselves and their property through the law;
- guidance and assistance in seeking help as a consequence of abuse;
- be supported in making their own decisions about how they wish to proceed in the event of abuse and to know that their wishes will only be over-ridden if it is considered necessary for their own safety or the safety of others;

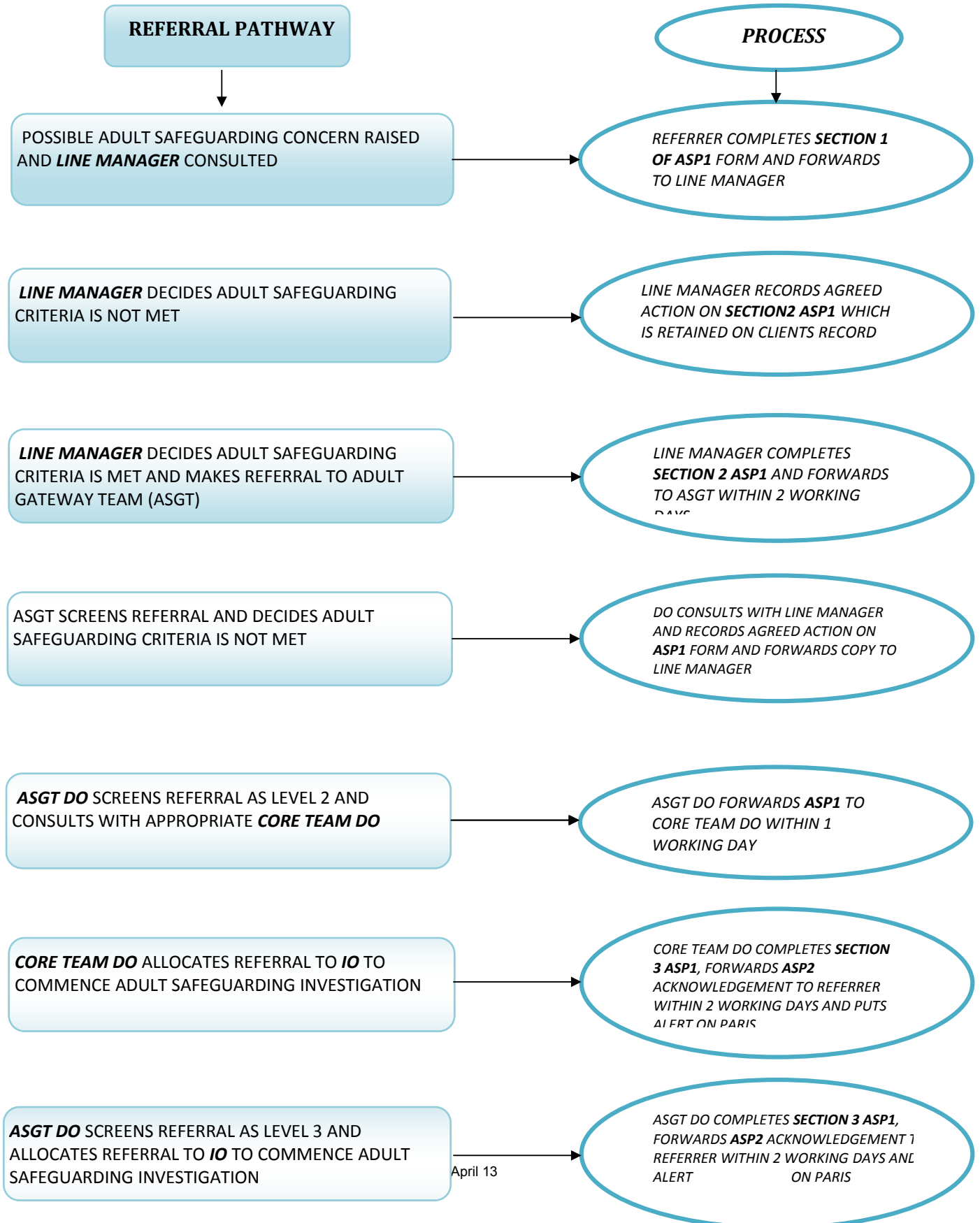
- be supported in bringing a complaint under any existing complaints procedure;
- be supported in reporting the circumstances of any abuse to independent bodies;
- have alleged, suspected or confirmed cases of abuse investigated urgently;
- receive appropriate support, education, counselling, therapy and treatment following abuse;
- seek legal advice or representation on their own behalf;
- seek redress through appropriate agencies;
- have their rights respected and to have their family, informal carers or advocates act on their behalf as appropriate.

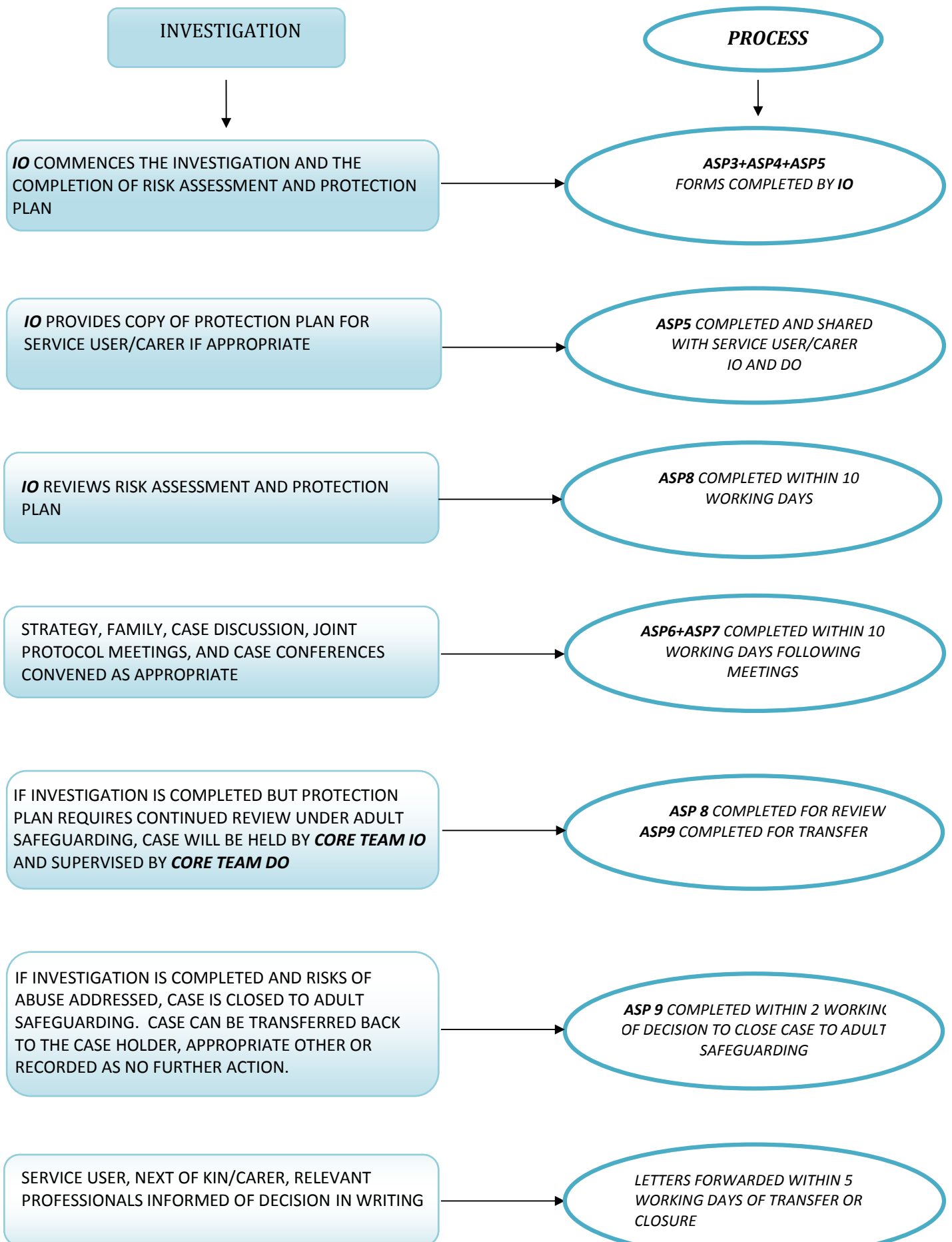


## Appendix 2

### Referral/Investigation Pathway Flow Chart

**ADULT SAFEGUARDING REFERRAL PATHWAY AND PROCESS FOR OLDER PEOPLE + PHSD**





## Appendix 3

### Trust Adult Safeguarding Procedures Forms

**BELFAST HEALTH AND SOCIAL CARE TRUST**  
**ADULT SAFEGUARDING PROCEDURES**  
**ASP1 - Alert / Referral Information**

*Please ensure Sections 1 & 2 are fully completed before referral to DESIGNATED OFFICER*

<b>NAME:</b>	<b>DATE OF BIRTH:</b> <i>(If not known, please give approximate age)</i>	<b>DATE OF REFERRAL:</b>
<b>ADDRESS:</b>	<b>GENDER:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>SERVICE GROUP:</b>
<b>POSTCODE:</b>	<b>TELEPHONE NO:</b>	<b>COMPUTER NO:</b>

**SECTION ONE**

<b>DETAILS OF REFERRER</b> <i>(the person who brings the concerns to the attention of your agency)</i>	
<b>Name:</b>	<b>Relationship to service user:</b>
<b>Job title and agency:</b>	<b>Contact number:</b>

	<u>Name</u>	<u>Address &amp; Tel. No.</u>
<u>Key Worker</u>		
<u>Care Manager</u>		
<u>G.P</u>		
<u>Other</u>		
<u>Family/Carer</u>		
<u>Significant other</u>		

<b>WHO WAS THE FIRST PERSON TO NOTE CONCERN:</b>	
<b>Name &amp; Tel No:</b>	<b>Date:</b>

<b>WHAT IS THE MAIN FORM OF SUSPECTED, ADMITTED OR KNOWN ABUSE?</b>		
<input type="checkbox"/> Physical	<input type="checkbox"/> Sexual	<input type="checkbox"/> Institutional abuse
<input type="checkbox"/> Financial	<input type="checkbox"/> Neglect	<input type="checkbox"/> Psychological
<input type="checkbox"/> Discrimination	<input type="checkbox"/> <b>OTHER</b>	

<b>DOES THIS REFERRAL ORIGINATE FROM:</b>	
<input type="checkbox"/> Acute Hospital	<input type="checkbox"/> MARAC
<input type="checkbox"/> Adult Mental Health Unit	<input type="checkbox"/> Regulated Facilities

- \* Section 1 – completed by Referrer
- \* Section 2 – completed by line manager
- \* Section 3 – completed by Designated Officer

Please ensure Sections 1 & 2 are fully completed before referral to D.O.

**ASP1 - Alert / Referral Information**

<b>INCIDENT REPORT</b>	
<u>Background information: (To include factors precipitating referral, home circumstances, support available, INCLUDING issues of capacity)</u>	
<b>INCIDENT REPORT – LOCATION / DATE / TIME OF INCIDENT</b> <i>(Please give exact details of what has been reported and if appropriate, note injuries on the attached body chart)</i>	
<b>HAVE THERE BEEN PREVIOUS CONCERNS OR EVIDENCE OF ABUSE TO YOUR KNOWLEDGE?</b>	
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/K <i>(If yes, what was the nature of the concern and the outcome)</i>	

<b>THE SERVICE USER'S USUAL LIVING ARRANGEMENTS</b>	
Does service user live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does alleged abuser live with service user?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is service user's present location different from home address?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>HAVE YOU TAKEN ANY ACTION DUE TO EMERGENCY SITUATION TO AVOID IMMEDIATE SERIOUS RISK?</b>	
Was immediate protection needed for Service User:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Detail:	
Was immediate protection taken for others in the vicinity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Detail:	

**ASP1 - Alert / Referral Information**

SERVICE USER'S KNOWLEDGE OF REFERRAL	
Does person know that a referral may be made? Has the person consented to a referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

DETAILS OF ALLEGED PERPETRATOR		
Name:	Date of birth:	<input type="checkbox"/> M <input type="checkbox"/> F
Address:		
Does the alleged perpetrator know that an allegation has been made against them?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K	
<u>Is alleged perpetrator known to service user?</u> Please specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Family member	<input type="checkbox"/> Another service user	<input type="checkbox"/> Paid carer
<input type="checkbox"/> Trust employee	<input type="checkbox"/> Other	

ANY ADDITIONAL INFORMATION RELEVANT TO THE REFERRAL <i>(Please note the views of others you have consulted and note any difference of opinion)</i>

<b>SIGNATURE:</b>	<b>DATE:</b>
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**ASP1 - Alert / Referral Information**

**SECTION TWO**

<b>ACTIONS AGREED BY LINE MANAGER</b>
<input type="checkbox"/> <b>No further action under Adult Safeguarding Procedures</b> <i>(Prompt: Please note if previous ASP1 alerts have been raised in this case)</i>
<input type="checkbox"/> <b>Further screening / information required prior to a decision being made</b>
<input type="checkbox"/> <b>Referral to Designated Officer for Investigation under Adult Safeguarding Procedures</b>
<input type="checkbox"/> <b>Referral to Adult Safeguarding Team</b>
<b>Is there a need to notify:</b> <input type="checkbox"/> <b>Quality Monitoring Officer</b> <input type="checkbox"/> <b>RQIA</b> <input type="checkbox"/> <b>PSNI</b>
<b>Is there a need to consider any immediate Human Rights issues</b> <input type="checkbox"/> (drop down of Convention Human Rights)

<b>DETAILS OF DECISION MAKING</b>

<b>SIGNATURE:</b>	<b>DATE:</b>
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**ASP1 - Alert / Referral Information**

**SECTION THREE**

OUTCOME OF INITIAL STRATEGY DISCUSSION
<input type="checkbox"/> Referral not appropriate for Adult Safeguarding Procedures <input type="checkbox"/> Further information required before an investigation is instigated <input type="checkbox"/> Referral accepted for Investigation under Adult Safeguarding Procedures and allocated to:  Name: _____ Date _____

ADDITIONAL INFORMATION IN RELATION TO THE REFERRAL

ACTIONS AGREED BY DESIGNATED OFFICER UNDER ADULT SAFEGUARDING PROCEDURES	DATE:
--	-------

Is immediate action required to protect the adult in need of protection?  
 Yes     No     Not Known

Is there a need to preserve possible forensic evidence Urgent medical attention required Additional care resources or staff provided Place of safety or respite admission required Removal of alleged perpetrator Are there any immediate Human Rights issues (drop down needed) Other (please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

Do Joint Protocol Procedures need to be considered?     Yes     No     More info required  
*(if Yes, please complete AJP1)*

**OUTCOME :**

Single Agency Investigation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trust Lead Investigation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint Protocol Investigation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ABE Referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do the RQIA need to be informed?     Yes     No     Not Known  
*If yes:-*  
 Name of Inspector: \_\_\_\_\_

**ASP1 - Alert / Referral Information**

Does the Trust need legal advice?  Yes  No  Not Known

Date of Contact: \_\_\_\_\_

**OTHER CONSIDERATIONS FOR ALLOCATION OF REFERRAL**

(a) Has the service user any preferences relating to who should carry out the investigation? (e.g. Gender)  Yes  No  N/K  
If Yes, please specify :

(b) Has the adult in need of protection any other special requirements?  Yes  No  N/K  
If Yes, please specify :

(C) Are there issues of safety for the worker?  Yes  No  N/K  
If Yes, state what safeguards are in place:

Will the adult in need of protection be visited on the same day as referral received?  Yes  No  
If No, state reasons:

<b>SIGNATURE OF DESIGNATED OFFICER:</b>	<b>DATE:</b>
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**BELFAST HEALTH AND SOCIAL CARE TRUST  
ADULT SAFEGUARDING PROCEDURES**

**ASP2 - ACKNOWLEDGEMENT OF REFERRAL**

*To be completed by the Designated Officer and returned to Referrer within 2 days*

<b>NAME:</b>	<b>ADDRESS:</b>	<b>DATE OF BIRTH:</b>
	<b>TELEPHONE NO:</b>	
<b>OUTCOME OF REFERRAL RECEIVED</b>		
<p><b>Referral not appropriate for Adult Safeguarding Investigation</b> <input type="checkbox"/></p> <p><b>Adult Safeguarding Investigation commenced</b> <input type="checkbox"/></p> <p><b>Name of Designated Officer</b> _____</p> <p><b>Contact telephone number</b> _____</p> <p><b>Name of Investigating Officer</b> _____</p> <p><b>Address</b> _____</p> <p><b>Contact telephone number</b> _____</p> <p><b>SIGNATURE OF DESIGNATED OFFICER</b> _____</p> <p><b>DATE</b> _____</p>		

**BELFAST HEALTH AND SOCIAL CARE TRUST**

**ADULT SAFEGUARDING PROCEDURES**

**ASP3 - SIGNIFICANT INTERVIEW / EVENT REPORT**

<b>NAME OF PERSON INTERVIEWED:</b>		<b>ADDRESS:</b>	
		<b>TEL. NO:</b>	
<b>COMPUTER NO:</b>			
<b>NAME OF INTERVIEWER:</b>			
<b>DATE:</b>		<b>TIME:</b>	<b>VENUE:</b>
<b>PURPOSE OF THE INTERVIEW:</b>			
<b>REPORT OF INTERVIEW / EVENT:</b>			

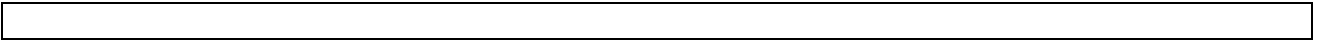
**ASP3 - SIGNIFICANT INTERVIEW / EVENT REPORT**

SIGNIFICANT INTERVIEW / EVENT REPORT (CONTINUED)	
<b>SUMMARY ACTION AGREED:</b> <i>(IS DASH FORM REQUIRED)</i>	
<b>SIGNATURE OF INTERVIEWER</b> _____	<b>DATE</b> _____



**ASP4 - INVESTIGATIVE REPORT/ASSESSMENT OF RISK**

<b>4. PHYSICAL HEALTH:</b>	
<b>5. SENSORY DISABILITY:</b> <input type="checkbox"/> Visual <input type="checkbox"/> Hearing <input type="checkbox"/> Deaf/ Blind	
<b>6. LEARNING DISABILITY - LEVEL OF DISABILITY:</b>  SERVICE USERS PERCEPTION OF DISABILITY:	
<b>7. MENTAL HEALTH:</b> <i>Prompt – see Consent Issues and the Vulnerable Adult</i>	
Has a psychiatric assessment been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes please specify)	
Date:	By whom:
Diagnosis:	
Other information regarding mental state/health:	
<b>8. CAPACITY / consent to issues under investigation:</b> (Please include relevant reports / opinions and bear in mind how client's capacity might be enhanced):	
<b>9. STATUTORY / LEGAL ORDERS</b> (Are any of the following statutory/protective measures already in place or were they previously used or considered under the mental health order?)	
<input type="checkbox"/> Power of Attorney/Enduring Power of Attorney	<input type="checkbox"/> Referral to Office of Care & Protection M.H.O.
<input type="checkbox"/> Non-Molestation Order	<input type="checkbox"/> Harassment Order
<input type="checkbox"/> Application for Guardianship M.H.O.	<input type="checkbox"/> Admission for psychiatric assessment M.H.O.
<input type="checkbox"/> Detained for treatment under M.H.O.	<input type="checkbox"/> Other ( <i>details</i> )
<b>10. FINANCIAL CIRCUMSTANCES</b> (Only if relevant)	
National Insurance No: _____	
In receipt of Benefits:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give details: _____	
Other income:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give details: _____	
Agent/ Appointee/ Controller in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give details: _____	
<b>11. CARER'S ASSESSMENT:</b> <input type="checkbox"/> Offered <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <input type="checkbox"/> Not applicable	





**ASP4 - INVESTIGATIVE REPORT/ASSESSMENT OF RISK**

**RISK ANALYSIS**

<b>RISK IDENTIFIED</b>			
<b>IDENTIFIED BY WHOM</b>			
<b>SPECIFIC EVIDENCE OF RISK / ABUSE</b>			
<b>PATTERN OF ABUSE</b>	Isolated <input type="checkbox"/> Occasional occurrence <input type="checkbox"/> Repeated occurrence <input type="checkbox"/> Established pattern <input type="checkbox"/>	Isolated <input type="checkbox"/> Occasional occurrence <input type="checkbox"/> Repeated occurrence <input type="checkbox"/> Established pattern <input type="checkbox"/>	Isolated <input type="checkbox"/> Occasional occurrence <input type="checkbox"/> Repeated occurrence <input type="checkbox"/> Established pattern <input type="checkbox"/>
<b>PROBABILITY REOCCURRING</b>	Unlikely <input type="checkbox"/> Likely <input type="checkbox"/> High Probable <input type="checkbox"/> Certainty <input type="checkbox"/>	Unlikely <input type="checkbox"/> Likely <input type="checkbox"/> High Probable <input type="checkbox"/> Certainty <input type="checkbox"/>	Unlikely <input type="checkbox"/> Likely <input type="checkbox"/> High Probable <input type="checkbox"/> Certainty <input type="checkbox"/>
<b>SEVERITY OF RISK</b>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Serious <input type="checkbox"/> Death <input type="checkbox"/>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Serious <input type="checkbox"/> Death <input type="checkbox"/>	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Serious <input type="checkbox"/> Death <input type="checkbox"/>
<b>SITUATIONAL FACTORS</b>			
<b>POSITIVE FACTORS WHICH MINIMISE RISK</b>			
<b>SERVICE USER/ CARER'S PREFERRED CHOICE / EXPRESSED WISHES</b>			
<b>ADDITIONAL COMMENT</b>			

**ASP4 - INVESTIGATIVE REPORT/ASSESSMENT OF RISK**

**13. RISK TO OR FROM OTHERS**

Are there risks to children and young people?  Yes  No

Has this been referred to the appropriate agency?  Yes  No

*If yes, please note who the referral was made to:* \_\_\_\_\_

Are there adults at risk of harm?  Yes  No

*If yes, note the discussion and action agreed with the Designated Officer:*

Where appropriate have support /services been offered to the person allegedly responsible for the abuse?

Yes  No *(if yes, please specify):*

**14. HUMAN RIGHTS CONSIDERATIONS: (HUMAN RIGHTS ASP7 TO BE COMPLETED IN ALL JOINT PROTOCOL CASES)**

Identify the Human Rights that have been considered:  
*(See attached European Convention guidance and please give details)*

Have any of these Human Rights been interfered with?  Yes  No

If yes please complete Human Rights Consideration Form ASP7

**15. MARAC (Multi Agency Risk Assessment Conference)**

Has a DASH form been completed?  Yes  No

Has a referral been made to MARAC ?  Yes  No

*If yes state the date of referral* \_\_\_\_\_

**ASP4 - INVESTIGATIVE REPORT/ASSESSMENT OF RISK**

**16. INVESTIGATION OUTCOME**

- Further investigation required
- Allegations are unconfirmed
- Other (please specify) \_\_\_\_\_
- Confirmed abuse
- Abuse not substantiated

**WHERE ALLEGATIONS ARE CONFIRMED PLACE X IN THE BOX TO NOTE THE MAIN FORM OF ABUSE.  
IF THERE ARE OTHER TYPES OF ABUSE PLEASE TICK RELEVANT BOX.**

- PHYSICAL
- FINANCIAL
- DISCRIMINATION
- SEXUAL
- NEGLECT
- OTHER (please specify)
- PSYCHOLOGICAL/EMOTIONAL
- INSTITUTIONAL ABUSE

**DETAILS OF DECISION MAKING**

**17. HAS A CASE DISCUSSION / CONFERENCE BEEN CONVENED?**

**Yes** DATE \_\_\_\_\_

Client invited  Yes  No

If no give reason: \_\_\_\_\_

Carer invited?  Yes  No

If no give reason: \_\_\_\_\_

Advocate invited?  Yes  No

If no give reason: \_\_\_\_\_

**No** (please state the reason)

**SERVICE USER'S SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

**SIGNATURE OF INVESTIGATING OFFICER** \_\_\_\_\_

**DATE** \_\_\_\_\_

**SIGNATURE OF DESIGNATED OFFICER** \_\_\_\_\_

**DATE** \_\_\_\_\_

## BELFAST HEALTH AND SOCIAL CARE TRUST

### ADULT SAFEGUARDING PROCEDURES

#### ASP5 - PROTECTION PLAN

<b>NAME:</b>	<b>DATE CREATED:</b>	<b>DATE OF COMMENCEMENT:</b>	<b>DATE OF REVIEW:</b>
--------------	----------------------	------------------------------	------------------------

RISK	ASSESSED NEED	INTERVENTION	BY WHOM	REASON FOR NOT TAKING ANY ACTION
1.				
2.				
3.				
4.				
5.				

**UNMET NEEDS:** *(If there are unmet needs, identify when this need can be met and / or the alternative services that have been provided)*

ARE ANY OF THE FOLLOWING ACTIONS REQUIRED *(tick all appropriate boxes)*

- |   |   |
|---|---|
| <input type="checkbox"/> REFERRAL TO THE OFFICE OF CARE AND PROTECTION<br><input type="checkbox"/> ADMISSION TO A CARE FACILITY<br><input type="checkbox"/> NON-MOLESTATION ORDER<br><input type="checkbox"/> DASH FORM | <input type="checkbox"/> APPLICATION FOR GUARDIANSHIP M.H.O.<br><input type="checkbox"/> ADMISSION FOR ASSESSMENT M.H.O.<br><input type="checkbox"/> REFERRAL TO MARAC<br><input type="checkbox"/> CARER'S ASSESSMENT |
|---|---|

**ASP5 – Protection Plan**

SERVICE USER'S / CARER'S COMMENTS

<b>SERVICE USER'S SIGNATURE:</b>	<b>AND/OR CARER / ADVOCATE / REPRESENTATIVE'S SIGNATURE:</b>
<b>DATE:</b>	<b>DATE:</b>

<b>INVESTIGATING OFFICER SIGNATURE:</b>	<b>DESIGNATED OFFICER SIGNATURE:</b>
<b>DATE:</b>	<b>DATE:</b>

## BELFAST HEALTH AND SOCIAL CARE TRUST

### ADULT SAFEGUARDING PROCEDURES

#### ASP6 - MINUTES

*This provides a template to record who attended the meeting, reports submitted and future review arrangements. The Designated Officer will also include a minute of the essential facts, discussion and decisions taken at the meeting.*

<b>NAME:</b>	<b>ADDRESS:</b>	<b>DATE OF BIRTH:</b>
<b>COMPUTER NO:</b>	<b>POSTCODE:</b>	<b>GENDER: M <input type="checkbox"/> F <input type="checkbox"/></b>
<b>VENUE:</b>		<b>DATE</b>
<b>CHAIR PERSON:</b>		
<b>WAS THE SERVICE USER INVITED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>WAS THE SERVICE USER IN ATTENDANCE?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <i>(if not give details)</i>		
<b><u>OTHERS INVITED I.E. ADVOCATE OR CARER</u></b>		
NAME _____	IN ATTENDANCE	YES <input type="checkbox"/> NO <input type="checkbox"/>
NAME _____	IN ATTENDANCE	YES <input type="checkbox"/> NO <input type="checkbox"/>
IF NOT INVITED OR DID NOT ATTEND SPECIFY REASON _____		
<b><u>NAME OF THOSE PRESENT</u></b>	<b><u>TITLE</u></b>	
<b>List of Apologies Received:</b>		
<b>Reports Submitted by:</b>		

## ASP6 – Minutes

### Free-text Minutes

**Prompt:** *please evidence due consideration of Human Rights issues through completion of ASP7.*

Signed \_\_\_\_\_

Dated \_\_\_\_\_

**BELFAST HEALTH AND SOCIAL CARE TRUST**  
**ADULT SAFEGUARDING PROCEDURES**

**ASP7 - HUMAN RIGHTS**

If you cannot answer a question, you cannot proceed to the next question. Only take action when you have completed the list.

1. Is there any necessity to take action? Yes No

What are you doing? Why are you doing it?

2. Is there any legal basis upon which to take action? Is there a statutory/mandatory/discretionary power you are using? If so, state it. If not, on what basis are you taking action? (*you should seek legal advice*)

3. What are the Human Rights implications of the proposed action? (Go through Convention List and mark the relevant article and the relevant limitation).

*Specify Article and Limitation*



**ASP7 - HUMAN RIGHTS**

4. Is the proposed action proportionate? Is the scale of the action appropriate to the size of the problem? (i.e. consider whether it is intrusive or invasive). Is there an alternative?

*Give reasons for your decision*

5. Is there an independent public remedy available? If not, consider what will be the effect of failure to give a remedy i.e. Ombudsman/Judicial Review/other Court action)

*Specify all available remedies*

6. If action is taken, is there “equality of arms”?  
Does the person have the same opportunity to gather evidence as you and present it to the Court/Tribunal?

7. Is the action the least possible one?  
Is it the least intrusive or invasive?

*Specify all available remedies*

**Signature of Investigating Officer:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature of Designated Officer:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**BELFAST HEALTH AND SOCIAL CARE TRUST**

**ADULT SAFEGUARDING PROCEDURES**

**ASP8 REVIEW OF PROTECTION PLAN**

*To be completed by the Investigating Officer*

<b>NAME:</b>	<b>ADDRESS:</b>	<b>DATE OF BIRTH:</b>
<b>COMPUTER NO:</b>	<b>POSTCODE:</b>	<b>GENDER: M <input type="checkbox"/> F <input type="checkbox"/></b>
<b>DATE OF LAST REVIEW:</b>		<b>DATE OF THIS REVIEW:</b>

<b>WHO HAS BEEN CONTACTED</b>		
<input type="checkbox"/> Service User	<input type="checkbox"/> Service user/NOK	<input type="checkbox"/> General Practitioner
<input type="checkbox"/> Psycho Geriatrician	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Hospital Nurse	<input type="checkbox"/> District Nurse	<input type="checkbox"/> Community Psychiatric Nurse
<input type="checkbox"/> Care Manager	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Social Care Co-ordinator
<input type="checkbox"/> Res. Day Care	<input type="checkbox"/> Rehab Worker	<input type="checkbox"/> PSNI
<input type="checkbox"/> RQIA	<input type="checkbox"/> Domiciliary Provider	<input type="checkbox"/> Community Nurse Learning Disability
<input type="checkbox"/> Advocate	<input type="checkbox"/> Other <i>(please specify)</i>	

<b>REVIEW AND AMEND PREVIOUS ANALYSIS OF RISK.</b> <i>Comments:</i>
--

<b>REVIEW AND AMEND PROTECTION PLANS.</b> <i>Comments:</i>
---

<p><b>ARE THERE ANY OUTSTANDING HUMAN RIGHTS CONSIDERATIONS</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes complete and/or review Human Rights Consideration form (ASP7)</p> <p><b>ARE THERE ANY UNRESOLVED ISSUES?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes, specify how these may be addressed:</p>
---

**ASP8 - REVIEW OF PROTECTION PLAN**

Will this case be reviewed under the Adult Safeguarding Procedures  Yes  No

**IF YES,**

Will the Review be via:

Supervision Date \_\_\_\_\_

Case Discussion/Conference Date \_\_\_\_\_

Will the designated and investigating officer remain the same  Yes  No

If no, please specify: Designated Officer \_\_\_\_\_

Investigating Officer \_\_\_\_\_

**IF NO,**

The Investigating Officer will continue with a key worker role

Case transferred to other key worker / service  
(please specify) \_\_\_\_\_

Close Case

Other (please specify) \_\_\_\_\_

**SIGNATURE OF INVESTIGATING OFFICER**

**DATE**

**SIGNATURE OF DESIGNATED OFFICER**

**DATE**

## BELFAST HEALTH AND SOCIAL CARE TRUST

### ADULT SAFEGUARDING PROCEDURES

#### ASP9 - CLOSURE / TRANSFER SUMMARY

<b>NAME:</b>	<b>ADDRESS:</b>	<b>DATE OF BIRTH:</b>
<b>COMPUTER NO:</b>	<b>POSTCODE:</b>	<b>GENDER:</b> M <input type="checkbox"/> F <input type="checkbox"/>

<b>AGREED ACTION</b>
Adult Safeguarding investigation completed <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>AGREED ACTION</b>
<b>Case transferred</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes complete Sections One and Two)</i>
<b>Case closed</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes complete Section One)</i>

<b>SECTION ONE</b>
Has anyone expressed a contrary view to transfer/closure? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes specify)</i>
Has the service user been informed in writing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have relevant others been informed in writing? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes specify)</i>

<b>SECTION TWO</b>
<input type="checkbox"/> Investigating officer will continue with a key worker role
<input type="checkbox"/> Transfer to other services <i>(specify)</i> _____
<input type="checkbox"/> Transfer to Investigating Officer in different team <i>(specify)</i> _____
<input type="checkbox"/> Transfer to other Trust <i>(specify)</i> _____
<input type="checkbox"/> Other <i>(specify)</i> _____

<b>SIGNED INVESTIGATING OFFICER</b>	<b>DATE</b>
<b>SIGNED DESIGNATED OFFICER</b>	<b>DATE</b>

## Appendix 4

### Emergency Duty Team ASP Form

**BELFAST HEALTH AND SOCIAL CARE TRUST  
ADULT SAFEGUARDING PROCEDURES**

**ASP – EDT Alert / Referral Information**

Please ensure Sections 1 is fully completed before referral to DESIGNATED OFFICER

<b>NAME:</b>	<b>DATE OF BIRTH:</b> (If not known, please give approximate age)	<b>DATE OF REFERRAL:</b>
<b>ADDRESS:</b>	<b>GENDER:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>SERVICE GROUP:</b>
<b>POSTCODE:</b>	<b>TELEPHONE NO:</b>	<b>COMPUTER NO:</b>

**SECTION ONE**

<b>DETAILS OF REFERRER</b> (the person who brings the concerns to the attention of your agency)	
<b>Name:</b>	<b>Relationship to service user:</b>
<b>Job title and agency:</b>	<b>Contact number:</b>

	Name	Address & Tel. No.
<b>Key Worker</b>		
<b>Care Manager</b>		
<b>G.P</b>		
<b>Other</b>		
<b>Family/Carer</b>		
<b>Significant other</b>		

<b>WHO WAS THE FIRST PERSON TO NOTE CONCERN:</b>	
<b>Name &amp; Tel No:</b>	<b>Date:</b>

<b>WHAT IS THE MAIN FORM OF SUSPECTED, ADMITTED OR KNOWN ABUSE?</b>		
<input type="checkbox"/> Physical	<input type="checkbox"/> Sexual	<input type="checkbox"/> Institutional abuse
<input type="checkbox"/> Financial	<input type="checkbox"/> Neglect	<input type="checkbox"/> Psychological
<input type="checkbox"/> Discrimination	<input type="checkbox"/> Other	

<b>DOES THIS REFERRAL ORIGINATE FROM:</b>	
<input type="checkbox"/> Acute Hospital	<input type="checkbox"/> MARAC
<input type="checkbox"/> Adult Mental Health Unit	<input type="checkbox"/> Regulated Facilities

- \* Section 1 – completed by Referrer
- \* Section 2 – completed by Designated Officer

Please ensure Sections 1 & 2 are fully completed before referral to Adult Safeguarding Gateway Team / Learning Disability DO / Mental Health Team DO

**ASP – EDT Alert / Referral Information**

<b>INCIDENT REPORT</b>	
Background information: <i>(To include factors precipitating referral, home circumstances, support available, INCLUDING issues of capacity)</i>	
<b>INCIDENT REPORT – LOCATION / DATE / TIME OF INCIDENT</b> <i>(Please give exact details of what has been reported and if appropriate, note injuries on the attached body chart)</i>	
<b>HAVE THERE BEEN PREVIOUS CONCERNS OR EVIDENCE OF ABUSE TO YOUR KNOWLEDGE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/K <i>(If yes, what was the nature of the concern and the outcome)</i>	

<b>THE SERVICE USER’S USUAL LIVING ARRANGEMENTS</b>	
Does service user live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does alleged abuser live with service user?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is service user’s present location different from home address?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>SERVICE USER’S KNOWLEDGE OF REFERRAL</b>	
Does person know that a referral may be made? Has the person consented to a referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>DETAILS OF ALLEGED PERPETRATOR</b> <i>(if known)</i>		
Name:	Date of birth:	<input type="checkbox"/> M <input type="checkbox"/> F
Address:		
Does the alleged perpetrator know that an allegation has been made against them?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K
Is alleged perpetrator known to service user? Please specify:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Family member	<input type="checkbox"/> Another service user	<input type="checkbox"/> Paid carer
<input type="checkbox"/> Trust employee	<input type="checkbox"/> Other	

**ASP – EDT Alert / Referral Information**

<b>IS THERE ANY ACTION REQUIRED TO AVOID IMMEDIATE SERIOUS RISK?</b>	
<b>Is immediate protection needed for Service User?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is immediate protection taken for others in the vicinity?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is there an agreed Interim Protection Plan?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>SIGNATURE:</b>	<b>DATE:</b>
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**ASP – EDT Alert / Referral Information**

**SECTION TWO**

ACTIONS AGREED BY EDT DESIGNATED OFFICER UNDER ADULT SAFEGUARDING PROCEDURES	
Was immediate action required to protect the adult in need of protection?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known
Was an interim protection plan agreed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a need to contact the PSNI Is there a need to preserve possible forensic evidence Urgent medical attention required Additional care resources or staff provided Place of safety or respite admission required Removal of alleged perpetrator Are there any immediate Human Rights issues Other ( <i>please specify</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Do Joint Protocol Procedures need to be considered? ( <i>if Yes, please complete AJP1</i> )  What is the outcome of the Joint Protocol consultation Single Agency Investigation Trust Lead Investigation Joint Protocol Investigation ABE Referral	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> More info required  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> No further action under Adult Safeguarding Procedures <input type="checkbox"/> Referral to Adult Safeguarding Gateway Team (Older People/PHSD POC) <input type="checkbox"/> Referral to Designated Officer (Learning Disability/Mental Health POC)	

<b>SIGNATURE OF EDT DESIGNATED OFFICER:</b>	<b>DATE:</b>
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**Appendix 5**

**Domestic Violence Guidance and Documentation – as produced by MARAC**

(see attached separate PDF document re MARAC processes)

## Appendix 6

### Criminal Justice Secure Messaging

**Criminal Justice Secure Messaging**

In order to safeguard vulnerable adults, there are occasions when Trust staff need to share information with PSNI. The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009) recognises the need for effective communication between Trust and PSNI in situations where a crime is suspected.

The Joint Review by RQIA and CJI of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults recommended that Trusts and PSNI consider ways to enhance communication and Joint Agency working. The Northern Ireland Adult Safeguarding Partnership (NIASP) in conjunction with PSNI have agreed that the Criminal Justice Secure Messaging Network should be implemented to facilitate communication and information sharing. This network affords a high level of security in terms of electronically exchanging information. However, staff are reminded that all the normal legal and practice considerations in terms of data protection, confidentiality and consent are still applicable.

Within Adult Services there is now the facility to set up CJSM user accounts for Adult Safeguarding Leads for each service group, all Designated Officers and staff trained in ABE. There may be other senior managers who would wish to have accounts set up and we will of course facilitate this. The process will be that staff are required to complete the e-Learning and then read and sign Terms & Conditions for connection to CJSM.

**The e-learning in relation to Criminal justice Secure Messaging is available on the Hub.** The e-learning provides all the relevant information required by staff. Staff will be expected complete the e-learning and sign Terms & Conditions before being placed on the system.

Please note that Yvonne McKnight and Pauline Stewart are the Administrators and the Terms & Conditions should be signed and forwarded, along with CJSM Details Template and your e-learning certificate, to [REDACTED]. You will then be added to CJSM system and sent a 'one-off' password which you need to change when you log onto CJSM. When using CJSM it is your responsibility to ensure that the person you are sending emails to is also registered on CJSM.

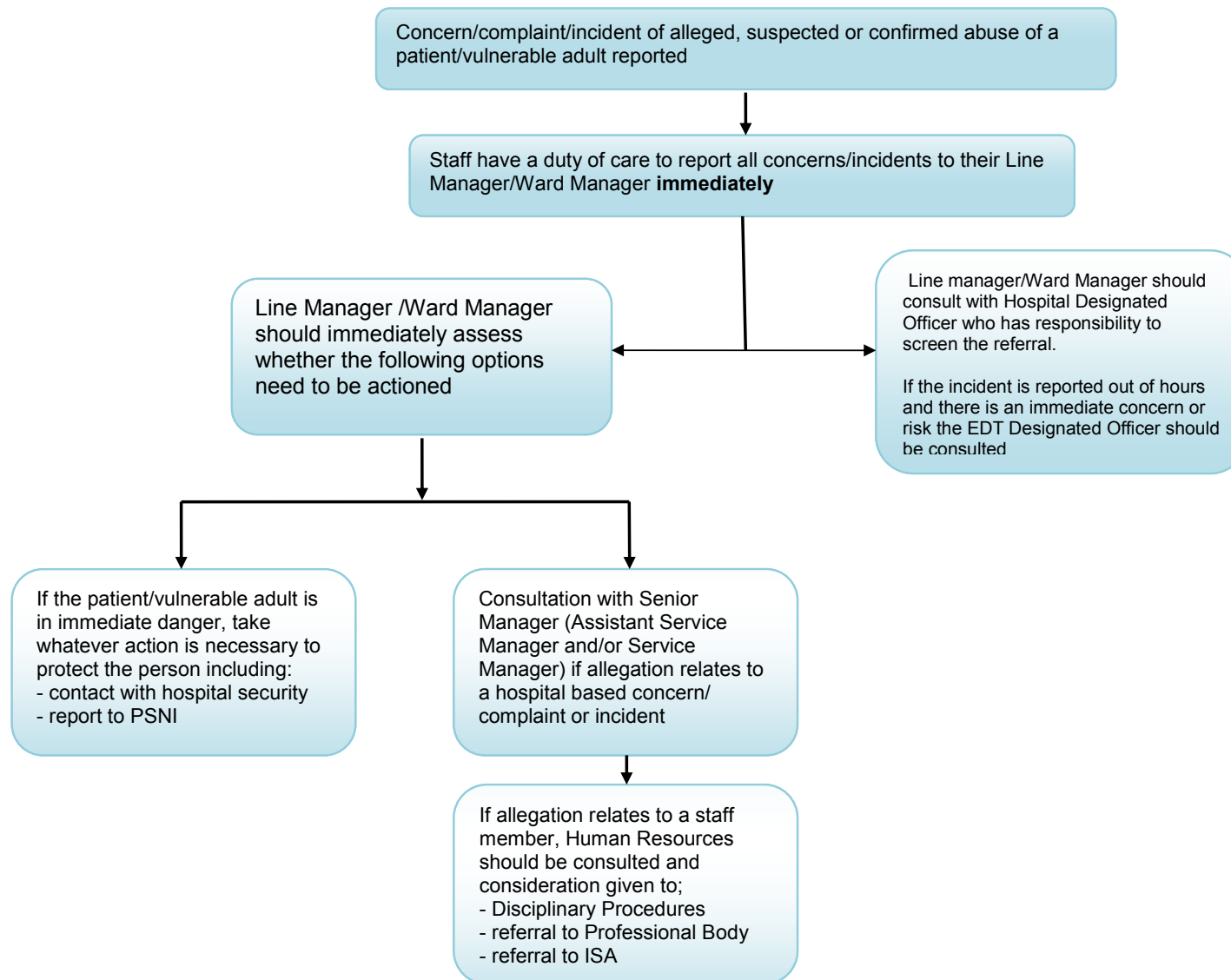
## Appendix 7

### Hospital Pathway Flow Charts

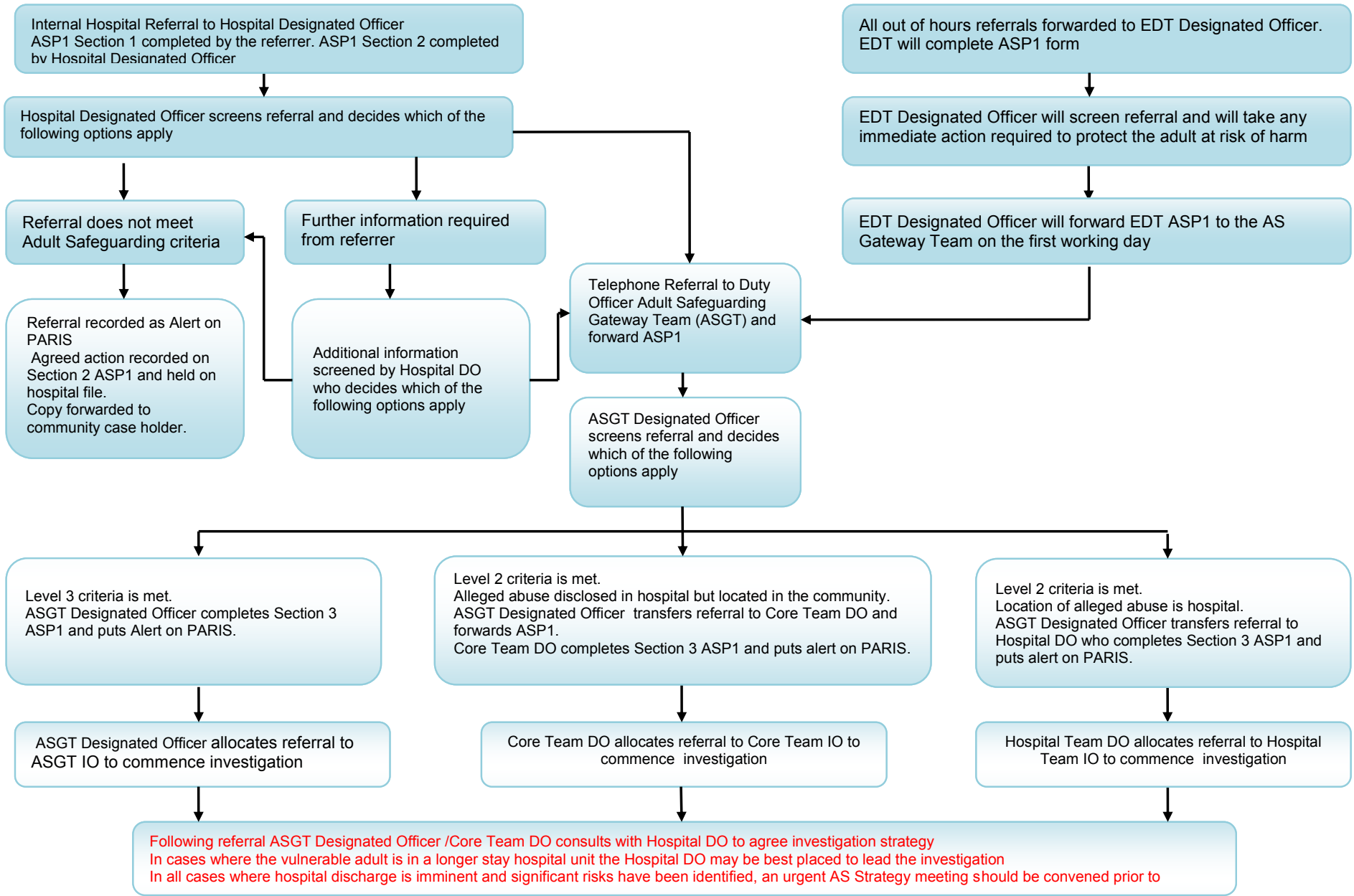
## Appendix 8

### Regulated Services Pathway Flow Chart

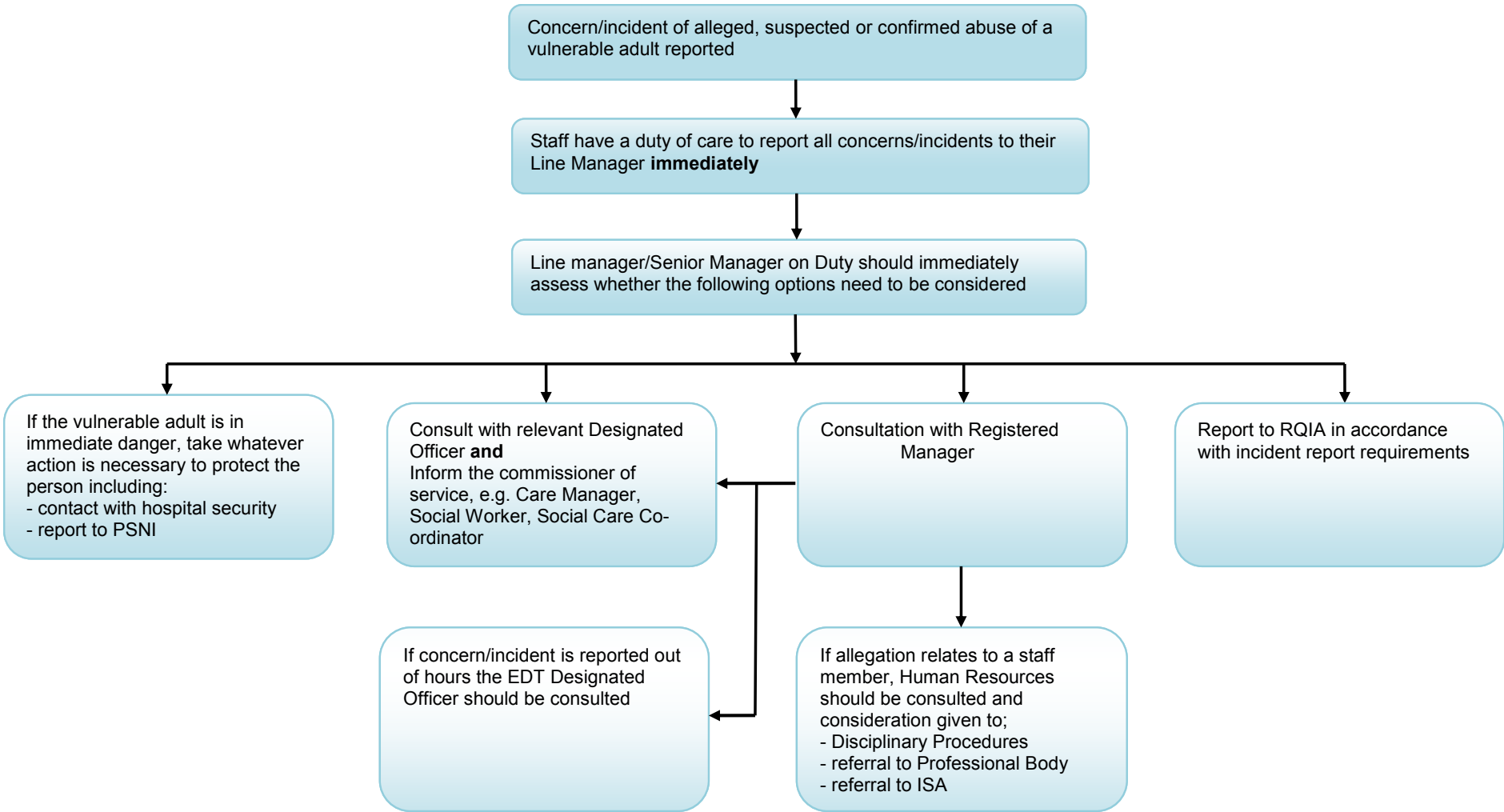
**HOSPITAL SETTING  
REPORTING PROCEDURE FOR RESPONDING TO VULNERABLE ADULT  
ABUSE CONCERNS**



**ADULT SAFEGUARDING HOSPITAL REFERRAL PATHWAY  
For Older People and PHSD Services**



**REPORTING PROCEDURE FOR RESPONDING TO VULNERABLE ADULT ABUSE CONCERNS IN REGULATED SERVICES**





## Appendix 9

### Trust Contact Lists

<b>Contact List for Designated Officers</b>
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<b>Social Worker Trained</b>	<b>Programme of Care</b>	<b>Work Place</b>	<b>Contact Number</b>
Pauls Potts	Older People	Carlisle ICT	95046327
Fiona Mc Kinney	Older People	Grove Centre	95045871
Roberta Myers	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Mairead Campbell	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Marbeth McKeown	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Anne Marie Fox	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Nuala Kelly	Older people	Provider Unit Carlisle Centre, 40 Antrim Road	90163707
Yvonne Mc Knight	Older People	Knockbracken Health Care Park	95046896
Deirdre Hegarty	Older People	Knockbracken Health Care Park	95046896
Ann Kernaghan	Older People & Physical Disability	Knockbracken Health Care Park	95046896
David Shaw	Older People	Arches Centre	90563330
Clayre Thompson	Older People	Arches Centre	90563330
Ruth Mc Coubrey (nee Adair)	Older People	Arches Centre	90563370
Margaret Dunn	Older People	Arches Centre	90563370
Susan Wilson	Older People	Knockbreda ICT	90631270
Geralyn Ainsworth	Older People	Shankill Centre	950493340
Sandra Cullen	Older people & Physical Disability	Knockbracken Health Care Park	90565707
Pat Fitzpatrick	Emergency Duty Team	Brae Valley	90565444
David Noonan	Older People	Bradbury Centre	90912090
Natalie Magee	Dementia In-patient Service	Knockbracken Health Care Park	95046710
Carmel Fairmichael	Older People	Shankill Well Being & Treatment Centre	95040334

Dermot Dawson	Older People	Beech Hall Well Being & Treatment centre	95040333
Lucia Lavery	Older People	Beech Hall Well Being & Treatment centre	95040333
Jacqueline O'Neill	Older People	Grove Health & Well Being Centre	95046062
Joan McCrudden	Older People	2 <sup>nd</sup> floor, Admin building, KHCP	95046890
Fionnuala McClelland	Older People	2 <sup>nd</sup> floor, Admin building, KHCP	95047134
Siobhan Murphy	Community Mental Health team for Older People	Knockbracken Health Care Park	95040346
Brenda Loughheed	Community Mental Health team for Older People	Knockbracken Health Care Park	95040346
David Allen	Community Mental Health team for Older People	Knockbracken Health Care Park	95040346
Colette Johnston	Physical Health & Disability/ Sensory support	Grove Health & Well Being Centre	95049012
Michelle Shannon	Physical Health & Disability	Grove Health & Well Being Centre	95045964
Siobhan McCorry	Physical Health & Disability	Grove Health & Well Being Centre	95046072
Jane McMillan	Physical Health & Disability/ Sensory support	Mount Oriel	90704138
Deborah Mc Bride	Physical Health & Disability	Mount Oriel	90704138
Kevin Burke	Physical Health & Disability	Mount Oriel	90704138
Tracy Reid	Oncology & Palliative Care	Crumlin Rd Health Centre	95048480
Aidan Best	Sensory Support	Bradbury Centre	95049623
Colette Ireland	Learning Disability	Mount Oriel	90630150
Mildred Lorimer	Learning Disability	Maureen Sheehan Centre	90242816

Carmel Drysdale	Learning Disability	Carlisle Centre 2 <sup>nd</sup> Floor 40, Antrim Road	95045674
Davy Mc Dowell	Learning Disability	Finaghy Library	90204820
Neil Kelly	Learning Disability	Everton complex	90566038
Aine Morrison	Learning Disability	Fairview	90802366
Barry Mills	Learning Disability	Muckamore Abbey Hospital	95047272
Clinton Stewart	Learning Disability	Muckamore Abbey Hospital	95046367
John Kell	Learning Disability	Muckamore Abbey Hospital	95047120
Michael Creaney	Learning Disability	Muckamore Abbey Hospital	95046457
Eileen Mc Larnon	Learning Disability	Muckamore Abbey Hospital	95046462
Rhoda Mc Bride	Mental Health	Woodstock	90737548
Michael Bell	Mental Health	Windsor Unit, BCH	95047875 90263929 07810182841
Nicola Marshall	Mental Health	Knockbracken	95046397
Mary O'Brien	Mental Health	Everton complex	95046787
Jackie Scott	Community Forensic Mental Health	Shannon, Knockbracken Health Care Park	95046670
Laura Duffy	Community Forensic Mental Health	Shannon, Knockbracken Health Care Park	95046693

Damian Murdock	Forensic Mental Health	Shannon, Knockbracken Health Care Park	95046598
Una Maguire	Forensic Mental Health	Shannon, Knockbracken Health Care Park	90 916837
Mandy Melaugh	Community Forensic Mental Health	Knockbracken Health Care Park	95046617
Aoine McMahon	Forensic Mental Health	Shannon, Knockbracken Health Care Park	95046378
Pauline McGovern	Mental Health	Howard Building, Twin Spires	90319088
Pauline Quinn	Mental Health	Howard Building, Twin Spires	90319088
Michael Foley	Mental Health-Addictions	Lower Crescent	95049727
Mandy Cowden	Hospital	RVH	90632450
Pat Knowles	Hospital	RVH	90632450
Mary Fagan	Hospital	RVH	90632450
Louise Derrick	Hospital	BCH	95046967
Christina Doyle	Hospital	BCH	95048117
Richard Hardy	Hospital	BCH: Cancer Centre	95048378
Lorraine McFarland	Hospital	Meadowlands and Intermediate Care	95047380
Tony Walsh	Hospital	Musgrave Park Hospital	95048657
Fred Davidson	Hospital	Mater Hospital	95047294

Mary Diamond	Care Management	Shankill Resource Centre	95049022 95049151
Fionna McGuigan	Older people	Shankill Well Being & Treatment Centre	95040334
Jane Barry	EDT	Brae Valley	90565444
William Morrow	EDT	Brae Valley	90565444

<b>Investigating Officers Contact List</b>
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<b>Staff member Trained</b>	<b>Service Group</b>	<b>Work Place</b>	<b>Contact Number</b>
Danny Quigg	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Ricki Reid	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Pam Borland	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Majella Fegan	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Denise Clarke	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Grace Ferguson Reihill	AS Gateway Team for Older people & Physical Disability	Knockbracken Health Care Park	95041744
Thelma McCullough	Older People	Grove Centre	90636858/50
Joe Mullholland	Older People	Grove Centre	90636858/50
Nikita Tully	Older People	Grove Centre	90636858/50
Marie Thompson	Older People	Grove Centre	90636858/50
Maureen Wright	Older People	Carlisle Centre	90245984
Jon Burwell	Older People	Carlisle Centre	90245984
Shirley Spence	Older People	Carlisle Centre	90245984
Joseph Looka	Older People	Carlisle Centre	90245984
Gillian Ferguson	Older People	Shankill Well Being & Treatment Centre	95040334
Karen McCartney	Older People	Shankill Well Being & Treatment Centre	95040334
Paul Finnegan	Older People <u>IDSS</u>	Shankill health & Well Being Centre	95040334
Allison Poole	Older People	Shankill health & Well Being Centre	95040334

Frances Muldoon	Older People	Shankill health & Well Being Centre	95040334
Tanya Killen	Older People	ICT Beech Hall Well Being & Treatment Centre	95040333
Anthony Fitzpatrick	Older People	ICT: Beech Hall Well Being & Treatment Centre	95040333
Zoe Mc McCullough	Older People	ICT: Beech Hall Well Being & Treatment Centre	95040333
Louise Labrooy	Older People	Carlisle Health & Well Being Centre	90163757
Elizabeth Mc Quillan	Older People	ICT Dundonald: Arches	90563370
Nadia Millar	Older People	ICT Dundonald: Arches	90563370
Deirdre Campbell	Older People	ICT Inner Arches	90563330
Mary Mullan	Older People	ICT Inner Arches	90563330
Dorothy Corbett	Older People	ICT Knockbreda	90631270
Liz Morton	Older People	ICT Knockbreda	90631270
Shirley Coleman	Older People Community Stoke Team	Shankill Centre	95040325
Richard Ferguson	Care Management- Older People	Shankill Centre	90315005
Liz Gallagher	Care Management- Older People	Shankill ICT	95040334
Shauna Breslin	Care Management- Older People	Shankill Resource Centre	90315005
Claire Mc Garrigle	Care Management- Older People	ICT Beech Hall Well Being & Treatment Centre	95040333
Mary Mc Corry	Care Management- Older People	ICT Beech Hall Well Being & Treatment Centre	95040333
Alma Caldwell	Care Management- Older People	ICT Beech Hall Well Being & Treatment Centre	95040333
Rose Mc Caffrey	Care Management- Older People	ICT Beech Hall Well Being & Treatment Centre	95040333
Nigel Coulson	Care Management- Older People	ICT Dundonald: Arches	90563370
Jane Adair	Care Management- Older People	ICT Dundonald: Arches	90563370
Alice McTavish	Care Management- Older People	ICT Arches Centre	90563330 90918085
Patricia o' Hara	Care Management- Older People	ICT Arches Centre	90563330 90918085
Bridget Milligan	Care Management- Older People	ICT Knockbreda	90631270



Trevor Conlon	Care Management- Older People	ICT Knockbreda	90631270
Edel Mullan	Care Management- Older People	ICT Knockbreda	90631270
Barbara Mc Meekin	Learning Disability	Carlisle Centre	90163595
Vincent Morrissey	Learning Disability	Carlisle Centre & Mount Oriel	90163595 90630147
Susan Maxwell	Learning Disability	Carlisle Centre	90163595
Donna Mulhern	Learning Disability	Carlisle Centre	90163595
Orla Mc Creary	Learning Disability	Carlisle Centre	90163595
Jacqui Mc Nair	Care Management: Learning Disability	Carlisle Centre	90163595
Damien McNairney	Learning Disability	Carlisle Centre	90163595
Catherine O' Callaghan	Learning Disability	Maureen Sheehan Centre	90242816
Therese Kane	Learning Disability	Maureen Sheehan Centre	90242816
Breige Donegan	Learning Disability	Maureen Sheehan Centre	90242816
Joy Wilson	Learning Disability	Maureen Sheehan Centre	90242816
Nora McAnallen	Learning Disability	Maureen Sheehan Centre	90242816
Bronagh Watters	Learning Disability	Maureen Sheehan Centre	90242816
Leona Gibney	Learning Disability	Maureen Sheehan Centre	90242816
Kathy Bhogal	Learning Disability	Maureen Sheehan Centre	90242816
Wendy Pevy	Learning Disability	Mount Oriel	90630150
Amanda Burgess	Learning Disability	Mount Oriel	90630150
Joanne Blair	Learning Disability	Mount Oriel	90630150
Catherine McGurk	Learning Disability	Mount Oriel	90630150
Catherine McKenna	Learning Disability	Mount Oriel	90630150
Rosie Fleming	Learning Disability	Mount Oriel	90630150
Karen Scott	Learning Disability	Finaghy	90204820
Lorna Brown	Learning Disability	Finaghy	90204820
Carol Witherspoon	Learning Disability	Finaghy	90204820

Anne Marie Byrne	Learning Disability	Finaghy	90204820
Cathy Quinn	Learning Disability	Finaghy	90204820
Janine Moan	Learning Disability	Finaghy	90204820
Amber Getty	Learning Disability	Finaghy	90204820 90163595
Fiona Campbell	Care Management: Learning Disability	Finaghy/ Mount Oriel	90204820 90630150
Rhonda Scott	Learning Disability	Muckamore Abbey	94483407
Pat Byrne	Learning Disability	Muckamore Abbey	94483454
Andrea Bell	Learning Disability	Muckamore Abbey	94483454
Ricky Stewart	Older People	Bradbury Centre	90912090
Andrea Smyth	Older People	Bradbury Centre	90912090
Ken Coyles	Sensory Support	Bradbury Centre	95040200
Marie O'Neill	Sensory Support	Bradbury Centre	95040200
Phyllis Kerr	Sensory Support	Bradbury Centre	95040200
Rhonda Shields	Sensory Support	Bradbury Centre	95040200
Martina Mageean	Sensory Support	Bradbury Centre	95040200
Donna White	Sensory Support/ Physical Health & Disability	Grove Health and Wellbeing Centre	90636800
Sharon Evans	Sensory Support/ Physical Health & Disability	Grove Health and Wellbeing Centre	90636800
Noirin Curran	Sensory Support/ Physical Health & Disability	Grove Health and Wellbeing Centre	90636800
Paul McClory	Sensory Support/ Physical Health & Disability	Grove Health and Wellbeing Centre	90636800
Christine Porter	Sensory Support/ Physical Health & Disability	Grove Health and Wellbeing Centre	90636800
Sharon Mulholland	Sensory Support / Physical Health & Disability	Grove Health and Wellbeing Centre	90636800
Lia Greer	Sensory Support/ Physical Health & Disability	Grove Health and Wellbeing Centre	90636800

Sharon McAleese	Sensory Support/ Physical Health & Disability	Grove Health and Wellbeing Centre	90636800
Harry Murphy	Sensory Support Physical Health & Disability	Grove Health and Wellbeing Centre	90636800
Orla Conway	Sensory Support Physical Health & Disability	Grove Health and Wellbeing Centre	90636800
Nicola Irvine	Physical Health & Disability/ Palliative Care	Crumlin Rd Health Centre	90741188
Olivia Clarke	Care Management- Physical Health & Disability	Grove Health and Wellbeing Centre	90636858
Pauline Weir	Care Management- Physical Health & Disability	Mount Oriel	90704138
Mary Louise Catherwood	Physical Health & Disability	Mount Oriel	90704138
Louise Piggott	Physical Health & Disability	Mount Oriel	90704138
Helen Kane	Physical Health & Disability	Mount Oriel	90704138
Liz Russell	Physical Health & Disability	Mount Oriel	90704138
Kay Murray	Physical Health & Disability	Mount Oriel	90704138
Frances Rae	Physical Health & Disability	Mount Oriel	90704138
Lianne Rea	Physical Health & Disability	Mount Oriel	90704138
Lorraine Finn	Sensory Support / Physical Health & Disability	Bradbury Centre	90912190
Denise Armstrong	Community Brain Injury Team	Knockbracken Health Care Park	90960085
Johnny Crowe	Sensory Support	Bradbury Centre	95040200
Henry Mayne	Sensory Support	Bradbury Centre	95040200
Linda Doonan	Sensory Support	Bradbury Centre	95040200
Nicola Mc Parland	Oncology & Palliative Care	Knockbreda Centre	90631200
Naomi Frazer	Forensic Mental Health	Shannon Clinic Knockbracken Health Care Park	90 916800
Toni Carlile	Community Forensic Mental Health	Shannon Clinic Knockbracken Health Care Park	90 916800

Paul Keenan	Community Forensic Mental Health	Knockbracken Health Care Park	90565632
Deirdre Mc Kerr	Community Forensic Mental Health	Knockbracken Health Care Park	90565632
Jenny Harron	Forensic Mental Health	Knockbracken Clinic, Knockbracken Health Care Park	90565423
Seamus McGrenaghan	Forensic Mental Health	Knockbracken Clinic, Knockbracken Health Care Park	90565423
Jackie Carr	Community Mental Health	Woodstock Lodge	90737548
Orla Brooks	Community Mental health	Woodstock Lodge	90737548
Mark Johnston	Community Mental Health	Woodstock Lodge	90737548
David Wylie	Community Mental Health	Woodstock Lodge	90737548
Lydia Scholes	Addiction Service	Woodstock Lodge	90737573
Mark Mulligan	Community Mental Health	Woodstock Lodge	90737548
Mairead Mc Veigh	Community Mental Health	Woodstock Lodge	90737548
Ken Wilson	Community Mental Health	Twin Spires	90417410
Emma Mc Farland / McDonald	Community Mental Health	Twin Spires	90417410
Janine Gillespie	Community Mental Health	Twin Spires	90417410
Jenny Harkin	Community Mental Health	Howard Buildings, Twin Spires	90319088
Nicola Aitcheson	Recovery Mental Health	Howard Buildings, Twin Spires	90319088
Nicola Marsh	Community Mental Health	Everton	90566051
Graham Armour	Community Mental Health	Everton	90566051
Seamus Walsh	Community mental Health- Care Management	Everton	90566016
Sandra Curran	Community Addictions Team	Everton	90566057
Brian Gribben	Care Manager	Mental Health Co-Ordination Centre Knockbracken Health Care Park	90565650
Jim Carson	Community Mental Health	Knockbracken Clinic Health Care Park	90565423
Rose Mc Kenna	Mental Health Team for Older People	Knockbracken Health Care Park	95040346

Margaret Gibney	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Asling Laws	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Alison Bloomer	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Anne Maguire	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Brenda Mc Cartan	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Kathy Jenkins	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Eileen Jackson	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Cathryn (Kate) Connolly	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Sharon Moore	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Siobhan O'Connell	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Marie O'Neill	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Roisin Breen	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Carmel Treacy	Mental Health Team for Older People	Knockbracken Health Care Park	95040346
Mildred Philips	Mental Health Recovery team	Windsor	90263646
Browen O'Neil	Mental Health-Home Treatment team	Mater Hospital	90802495
Stephanie Codd	Hospital	BCH	90263600
Claire Henry	Hospital	BCH	90263600
Tony Donaghy	Hospital	BCH	90263600

Taralisa Allen	Hospital	BCH	90263600
George Potts	Hospital	BCH	90263600
Bernie Sands	Hospital	BCH- Cancer Centre	90263600
David Evans	Hospital	BCH- Cancer Centre	90263600
Pauline Shelcott	Hospital	Meadowlands Musgrave Park Hospital	90902911
Linda Jenkins	Hospital (Intermediate Care)	Meadowlands Musgrave Park Hospital	90902359
Irene Montgomery	Hospital (Intermediate Care)	Meadowlands Musgrave Park Hospital	90902359
Mary Kate Kelly	Hospital	Musgrave Park	90902942
Rachel Pedder	Hospital	Foster Green	90944357
Sharon Rainey	Hospital	Mater	90802435
Donna Marie Henderson	Hospital	Mater	90802435
Julie Mc Closkey	Hospital	Mater	90802435
Evelyn Agnew	Hospital	Mater	90802435
Breid Eakin	Hospital	Mater	90802435
Eileen Christie	Hospital	Mater	90802435
Maura Chambers	Hospital	Mater	90802435
Joe Jameson	Hospital	RVH	90632450
Fionnuala Forde	Hospital	RVH	90632450
Gretta Thompson	Hospital	RVH	90632450
Fiona McCullough	Hospital	RVH	90632450
Julianne Conlon	Hospital	RVH	90632450
James Boyd	Hospital	RVH	90632450
Heather Harbinson	Hospital	RVH	90632450
Anne O' Toole	Hospital	RVH	90632450
Julianne Conlon	Hospital	RVH	90632450
Jacintha McCaffery	Hospital	RVH	90632450
Maura Welsh	Hospital	RVH	90632450
Paula Rooney	Hospital	RVH	90632450

Deborah Bell	Hospital	RVH	90632450
Michelle Armstrong	Hospital	RVH	90632450
Hilary Kerr	Emergency Duty Team	Brae Valley Annex	90565444
Rosemary Brown	Emergency Duty Team	Brae Valley Annex	90565444
Myra Napier	Emergency Duty Team	Brae Valley Annex	90565444
Berny Wilson	Emergency Duty Team	Brae Valley Annex	90565444
Alison Walker	Emergency Duty Team	Brae Valley Annex	90565444

**SOCIAL WORKERS TRAINED**  
**ACHIEVING BEST EVIDENCE**

<b>Social Worker Trained</b>	<b>Programme of Care</b>	<b>Work Place</b>	<b>Contact Number</b>
Mairead Campbell	Older People & Physical Health & Disability	Knockbracken Health Care Park	95041744
Roberta Myers	Older People & Physical Health & Disability	Knockbracken Health Care Park	95041744
Majella Fegan	Older People & Physical Health & Disability	Knockbracken Health Care Park	95041744
Marbeth McKeown	Older People & Physical Health & Disability	Knockbracken Health Care Park	95041744
Danny Quigg	Older People & Physical Health & Disability	Knockbracken Health Care Park	90 565707
Susan Wilson	Older People	Knockbreda ICT	90631270
Nicola Marsh	Mental Health	Everton complex	90 566051
Hugh Mulvenna	Mental Health	Dunluce HC	90 204431
Ken Wilson	Mental Health	Twin Spires	90 417410
Emma Mc Farland	Mental Health	Twin Spires	90 417410
Mark Johnston	Mental Health	Woodstock	90 737548
Denise Armstrong	Community Brain Injury	Knockbracken	90 565478
Johnny Crowe	Sensory Support	Bradbury Centre	90 912190
Berny Wilson	Emergency Duty Team	Brae Valley	90 564996
Colette Ireland	Learning Disability	Finaghy	90 204820
Anne-Marie Byrne	Learning Disability	Finaghy	90 204820
Orla Mc Creary	Learning Disability	Maureen Sheehan Centre	90 242816
Leona Giboney	Learning Disability	Maureen Sheehan Centre	90 242816
Carmel Drysdale	Learning Disability	Carlisle Health & Wellbeing Centre,	90 163595
Barbara Mc Meekin	Learning Disability	Carlisle Health & Wellbeing Centre,	90 163595



## **Appendix 10**

### **Key Contact Details**

**Key Contacts / External Agencies****Contact details for the Regulation and Quality Improvement Authority between 9.00am – 5.00pm Monday to Friday**

The RQIA Headquarters is located in Belfast at:

The Regulation and Quality Improvement Authority  
9<sup>th</sup> Floor Riverside Tower  
5 Lanyon Place  
Belfast  
BT1 3BT  
Phone: (028) 9051 7500

RQIA is an independent professional body with responsibility for quality assurance in relation to regulated services. They have an inspection function and are required to ensure that legislative requirements in relation to regulation and standards are met.

In relation to vulnerable adult abuse allegations, regulated services are required to follow RQIA reporting procedures.

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**Police Service of Northern Ireland: 0845 600 8000****Contact details for referrals to Public Protection Units between 9.00am – 5.00pm Monday to Friday****A District – North & West Belfast**

Inspector Ext 28950 Sergeant Ext 28826

**B District – South & East Belfast**

Inspector Ext 23594 Sergeant Ext 23579

**C District – North & South Down, Ards and Castlereagh**

Inspector Ext 31160 Sergeant Ext 15782

Allegations of abuse which constitute a crime must be reported to PSNI and consideration given to whether the 'Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' (July 2009) is applicable.

In all referrals regarding Vulnerable Adults, the Sergeant attached to the relevant PPU will be the first point of contact.

Outside of usual office hours (9.00am – 5.00pm, Monday to Friday) the Duty Inspector in the relevant District should be contacted.

**Independent Safeguarding Authority:**

Po Box 181  
Darlington  
County Durham  
DL1 9FA

Phone: 0300 123 1111

The Independent Safeguarding Authority (ISA) is a non-departmental public body with responsibility for implementation of the new Vetting and Barring Scheme in England, Wales and Northern Ireland. ISA will require all those working with vulnerable groups to undergo an enhanced vetting procedure before being allowed to commence any relevant duties.

Staff in regulated services will be required to register with ISA over a phased period of time, with implementation of new staff effective immediately. In addition, when concerns emerge regarding poor practice or abuse, consideration needs to be given to referral on to ISA regarding possible barring requirements

**Appendix 11**

There are 7 categories of abuse as defined in the Safeguarding Vulnerable Adults, Regional Adult Protection Policy & Procedural Guidance 2006.

These are:

- Physical (including inappropriate restraint or use of medication)
- Sexual
- Psychological
- Financial or Material
- Neglect and acts of omission
- Institutional
- Discriminatory

**Physical Abuse**

The infliction of physical pain, injury or coercion

*Physical Abuse can be:*

- Acts such as slapping, kicking, tripping, shaking, burning
- General rough handling- pushing
- Restraint: restricting freedom of movement
- Abuse of medication

*Possible indicators include:*

- Unexplained burns, cuts & fractures
- Bruises, welts, bite marks, injury shape similar to an object
- Prolonged interval between injury & treatment
- Malnutrition
- Signs of force feeding, e.g. bruising around the mouth
- Untreated medical problems
- Signs of under or over medication

**Sexual Abuse**

Sexual abuse includes acts to which the vulnerable adult has not consented, or is incapable of giving informed consent or was pressured into consenting.

*Sexual Abuse can include:*

- Harassment
- Taking photographs or videos
- Forced viewing of pornography or sexual acts
- Indecent exposure
- Touching –under or over clothing
- Masturbation- performed or demanded
- Penetration

*Possible indicators include:*

- Full or partial disclosure or hints
- Torn, stained or bloody underclothing
- Pain or itching, bruises or bleeding in genital area
- Sexually- transmitted disease, infections
- Love bites
- Change in sexual behaviour or language
- Pregnancy in a person who is not able to consent

**Financial Abuse**

Theft or conversion of money, objects, or property belonging to a person who is vulnerable against their best interests.

*Possible indicators include:*

- Evidence of theft or extortion
- Lack of necessary food or fuel
- Person lacks cash belongings or services that they can clearly afford
- Unusual or inappropriate bank account activity
- Refusing care because of finances
- Blocking access to material goods including affordable luxuries
- Denial of choice on financial grounds

**Emotional/Psychological Abuse**

This can include intimidation, humiliation, shouting, swearing, emotional blackmail and denial of basic human rights. Using racist language, preventing someone from enjoying activities or meeting friends.

*Possible indicators include:*

- Humiliation
- Harassment
- Threatening or insulting behaviour
- Enforced social isolation
- Intimidation and bullying
- Verbal abuse- shouting, swearing
- Emotional blackmail
- Tearfulness
- Low self esteem
- Confusion, agitation
- Coercion

**Institutional Abuse**

Neglect and poor professional practice may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to continual ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is often referred to as institutional abuse.

*Possible indicators include:*

- Excessive use of restraint/ inappropriate confinement (physical and chemical)
- Lack of privacy including open toileting and washing
- Conveyer belt basic care
- Lack of stimulation /deprived environment
- Dirty clothing or bed linen
- Poor staffing ratios
- No policy on management of continence
- Poor catering with little choice
- Inappropriate use of rules, custom and practice
- Lack of individual care plans properly implemented

## **Neglect and Acts of Omission**

This can include ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

*Possible indicators include:*

- Deprivation of medical attention
- Deprivation of food
- Lack of hygiene
- Lack of ventilation, heat or light
- Over/Under-medicated
- Failure to access appropriate medical care
- Malnourished
- Semi-comatose
- Dehydrated
- Bed sores, rashes, lice
- Coated with faecal matter/ urine stained
- Inadequately clothed
- Untrimmed toenails, matted hair
- Untreated medical needs
- Dry lips, pallor or excessive weight loss
- Dirty or inappropriate clothing for weather
- Shivering or low body temperature which might indicate hypothermia
- Lack of dentures, glasses or hearing aid
- Signs of infrequent bathing
- Physical or mental deterioration with no medical reason
- Confinement
- Person is seen wandering dangerously
- Lack of Food
- Inadequate or over medication
- Care standards that could lead to illness or accidents

## **Discriminatory Abuse**

Discriminatory abuse occurs when values, beliefs or culture result in a misuse of power that denies opportunity to some groups or individuals. It can be a feature of any form of abuse of an adult at risk, but can also be motivated because of age, gender, sexuality, disability, religion, class, culture, language, and race or ethnic origin

*Possible indicators include:*

- tendency for withdrawal and isolation
- fearfulness and anxiety
- being refused access to services or being excluded inappropriately
- resistance or refusal to access services that are required to meet assessed needs



Reference No: TP052/10

<b>Title:</b>	<b>PROTOCOL FOR THE RECRUITMENT AND EMPLOYMENT OF STAFF UNDER THE REQUIREMENTS OF THE SAFEGUARDING VULNERABLE GROUPS (NI) ORDER (SVGO) 2007 AND VETTING AND BARRING SCHEME, AS AMENDED BY THE PROTECTION OF FREEDOMS ACT 2012</b> Interim Guidance (Pending Further Review)		
<b>Author(s)</b>	Alison Kerr, Senior Manager, Human Resources [REDACTED] Louise Beckett, Senior Manager, Human Resources [REDACTED]		
<b>Ownership:</b>	<b>Marie Mallon, Director, Human Resources</b>		
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Date	Version	Author	Comments
23.03.10	V0.1	L Beckett	Initial Draft
09.06.10	V0.2	L Beckett	Final Draft
09.06.10	V1.0	L Beckett	Final Version
10.09.12	V1.1	A Kerr/ L Beckett	Revised Version
29.01.13	V2.0	A Kerr/ L Beckett	Revised Version

## **1.0 INTRODUCTION / PURPOSE OF POLICY**

### **1.1 Purpose**

Protocol for the Recruitment and Employment of Staff under the Requirements of the Safeguarding Vulnerable Groups (NI) Order (SVGO) 2007 and the Vetting and Barring Scheme, as amended by the Protection of Freedoms Act 2012

### **1.2 Objectives**

To provide guidance on the SVG Vetting and Barring Scheme as amended by the Protection of Freedoms Act 2012. This Policy will be subject to further reviews as result of the Government Review of the Vetting and Barring Schemes and consequently remains as interim guidance.

## **2.0 SCOPE OF THE POLICY**

The Protocol covers the responsibilities of the Trust, Line Managers and Human Resources Staff and applies to existing staff, potential employees, volunteers and disability placements on work experience.

## **3.0 ROLES/RESPONSIBILITIES**

The specific responsibilities of the Trust, its managers and Human Resources staff are outlined.

## **4.0 KEY POLICY PRINCIPLES**

The Protocol was developed as a result of the SVG (NI) Order 2007 which established the Vetting and Barring Scheme and replaces the former Protection of Children and Vulnerable Adults (NI) Order 2003.(POCVA)

Key Policy Statement(s)

1. The protocol outlines the legislative context and responsibilities under the SVG Vetting and Barring Scheme, as amended by the Protection of Freedoms Act 2012.
2. It sets out the main provisions of the VBS as it relates to conducting checks for new and current employees and the referral arrangements for existing employees.
3. It provides advice and clarification on the key elements of the VBS and a number of services for further information and documentation.

**5.0 IMPLEMENTATION OF POLICY****5.1 Dissemination**

This Policy should be disseminated throughout the Trust as it applies to existing staff, potential employees, volunteers and disability placements on work experience.

**5.2 Resources**

Further changes will be phased in during 2012 – 2014 as a result of the Protection of Freedoms Act 2012 which will require HR staff to further review the Protocol.

**6.0 MONITORING**

The Protocol will be kept under review to ensure compliance with any future legislative requirements. The Protocol will be formally reviewed on an annual basis in accordance with Section 7 Governance Arrangements as set out in this Protocol. This monitoring should include any Section 75 implications of implementing the policy.

**7.0 EVIDENCE BASE / REFERENCES**

The Protocol adheres to legislative requirements of the SVG Vetting and Barring Scheme. References: DHSSPS Generic Guidance, Sector Specific Guidance, DBS Referral Guidance and Access NI Guidance.

**8.0 CONSULTATION PROCESS**

The Protocol was fully consulted on with the Trusts SVG Stakeholders' Groups at which Service Groups, Trade Unions and Human Resources are represented. All review have been discussed at the Trust's Workforce Governance Steering Group and with the Trade Unions.

**9.0 EQUALITY STATEMENT**

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

**Major impact**

**Minor impact**

**No impact.**

**SIGNATORIES**

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



Date: 27 February 2013

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Name Marie Mallon  
Title Deputy Chief Executive/  
Director of Human Resources



Date: 27 February 2013

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Name Colm Donaghy  
Title Chief Executive



Belfast Health and  
Social Care Trust

**PROTOCOL FOR:**

**RECRUITMENT AND EMPLOYMENT OF STAFF  
UNDER THE REQUIREMENTS OF THE  
SAFEGUARDING VULNERABLE GROUPS (NI)  
ORDER (SVGO) 2007 AND THE VETTING AND  
BARRING SCHEME, AS AMENDED BY THE  
PROTECTION OF FREEDOMS ACT 2012**

**INTERIM GUIDANCE PENDING  
FURTHER REVIEW**

**DECEMBER 2012**

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# **Protocol for the Recruitment and Employment of Staff under the requirements of the Safeguarding Vulnerable Groups (NI) Order (SVGO) 2007 Vetting and Barring Scheme, as amended by the Protection of Freedoms Act 2012**

## **1 PURPOSE AND SCOPE OF PROTOCOL**

This Protocol outlines the key responsibilities of the Belfast Health and Social Care Trust (the Trust) in relation to the implementation arrangements for the SVGO Vetting and Barring Scheme as it relates to the employment of staff, the recruitment of prospective staff and the placement of students, volunteers, trainees and other non employees. The Trust has been entrusted with the care of children and vulnerable adults and must be confident that all the necessary safeguards and controls are in place to ensure that children and vulnerable adults are protected. The Trust has a range of responsibilities emanating from its statutory remit in respect of Fostering, Adoption and Early Years' Services. The practice across the Trust in these service sectors is informed by various Regulations, Policies and Procedures which can be accessed via the Social Work Social Care Governance service area.

This Protocol has been developed as part of the Trust's Safer Recruitment and Employment Framework in relation to the specific requirements for the Belfast Trust and **must** be read in conjunction with the more detailed Generic and Sector Specific Guidance on the Vetting and Barring Scheme which can be accessed at [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk) and the Referral Guidance which can be accessed at <http://www.homeoffice.gov.uk/publications/agencies-public-bodies/dbs/dbs-referrals-guidance/> The Protocol summarises the key details of the legislation and the Vetting and Barring Scheme and outlines the procedural arrangements which have been put in place to implement these. The Protocol has also been reviewed to take account of the Protection of Freedoms Act 2012 which sets out a range of changes to the disclosure and barring services. Not everything is changing but the first phase of changes will take effect from 10<sup>th</sup> September 2012, and these are as outlined in this Protocol. In addition changes effective from 1<sup>st</sup> December 2012 are now also stipulated within this protocol. The Protocol will be further reviewed as the subsequent changes are phased in.

## **2 LEGISLATIVE CONTEXT**

The Bichard Inquiry into the murders in Soham resulted in a recommendation for a new scheme that would ensure that everyone working in regulated activity with children and vulnerable adults is checked and registered. After

full consultation the Bichard Inquiry led to the Safeguarding Vulnerable Groups Act (SVGA) 2006 and the Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 which provide for the establishment of the Vetting and Barring Scheme. This Legislation and Scheme replaced the former Protection of Children and Vulnerable Adults (NI) Order 2003 (POCVA).

The Vetting and Barring Scheme became effective on 12 October 2009. It recognised the need for a single process to assess all individuals who wish to do certain work or volunteer with children and vulnerable adults. The Independent Safeguarding Authority (ISA) was established as part of this process across England, Wales and Northern Ireland with four statutory duties – to maintain a list of individuals barred from engaging in regulated activity with children; to maintain a list of individuals barred from engaging in regulated activity with vulnerable adults; to make well informed and considered decisions about whether an individual should be included in one or both barred lists; and to reach decisions as to whether to remove an individual from a barred list. The ISA and the Criminal Records Bureau (CRB) merged on 1<sup>st</sup> December 2012 to form the Disclosure and Barring Service. As a result it will be the Disclosure and Barring Service (DBS) who will maintain the barred lists and receive referrals from employers.

In addition, while the Vetting and Barring Scheme was to provide significant safeguards, it was part of a wider framework of safe recruitment practices. In particular Access Northern Ireland (ANI), which became effective in April 2008 and operated under the provisions of Part V of the Police Act 1997, was established by a joint programme between the NI Office, the DHSSPS, the Department of Education and the PSNI. It enabled organisations to make more informed recruitment decisions by providing criminal history information about anyone seeking paid or unpaid work in areas working with children and vulnerable adults. ANI offers two levels of disclosure Standard and Enhanced – each of which represents a different level of check.

A Standard Disclosure Certificate shows details of spent and unspent convictions and cautions – not cases pending.

An Enhanced Disclosure Certificate contains all the information in a Standard Disclosure and any further relevant information held in Police records eg information about attempted prosecutions that were unsuccessful or behaviour that might be indicative of criminal activity.

Standard Disclosure Certificates are no longer available for people working with children or vulnerable adults and an Enhanced Disclosure Certificate will be obtained in these circumstances.



Detailed information about ANI is available by accessing its website: [www.accessni.gov.uk](http://www.accessni.gov.uk)

In applying this Policy reference must be made to the Access NI Code of Practice, The Explanatory Guide and the Guide to Access NI.

Following concerns about the proportionality and bureaucracy of the Vetting and Barring Scheme (VBS), the Coalition Government committed to review the VBS and the criminal records regime. The NI Assembly agreed that the changes to disclosure and barring should be extended to Northern Ireland in order to maintain consistent safeguarding arrangements with England and Wales.

The Safeguarding Vulnerable Groups (Northern Ireland) Order (SVGO) 2007 sets out the framework for the VBS, so in order to implement the recommendations in the reviews; the SVGO was amended via the Protection of Freedoms Act 2012 which enabled changing the law as follows:

- Scaling back of Regulated Activity
- Repeal of Controlled Activity
- Repeal of Registration and Continuous Monitoring

### **3 MAIN PROVISIONS OF THE VETTING AND BARRING SCHEME, AS AMENDED BY THE PROTECTION OF FREEDOMS ACT 2012**

The Protection of Freedoms Act 2012 has introduced a new definition of Regulated Activity and abolished the Controlled Activity category with effect from 10<sup>th</sup> September 2012.

#### **a) Scaling Back of Regulated Activity**

The full legal definition of Regulated Activity is set out in Schedule 2 of the Safeguarding Vulnerable Groups (Northern Ireland) Order (SVGO) as amended in particular by the Protection of Freedoms Act 2012. Please refer also to the Information Leaflet – attached Appendix 1 and to Appendix 4 Overview of Disclosure and Barring Scheme Requirements

The new definition of Regulated Activity is essentially a scaling back of what was considered to be regulated activity to focus on work which involves close and unsupervised contact with vulnerable groups, including children.

The amended definition of Regulated Activity relating to **Children** comprises only:

- (i) Unsupervised activities: teaching, training, instructing, caring for or supervising children, or providing advice/ guidance on well-being, or driving a vehicle only for children;
- (ii) Work for a limited range of establishments ('specified places'), with opportunity for contact: e.g. schools, children's homes, childcare premises, a children's hospital **but** not work by supervised volunteers in those places;

Work under (i) or (ii) above is regulated activity only if done regularly, or if done overnight<sup>1</sup>.

Statutory guidance about supervision has been provided by the DHSS&PS to accompany the new definition of regulated activity and is as set out in Appendix 5 to this document.

- (iii) Relevant personal care, e.g. washing or dressing; or health care by, or supervised by, a professional;
- (iv) Registered childminding; and foster care

The DHSS&PS has provided guidance about supervision to which organisations must have due regard. The precise nature and level of supervision will vary from case to case. The duty means that organisations **must** ensure that the supervision in place is sufficient, in their judgement, to provide reasonable assurance for the protection of the children concerned.

Supervision must be:

- Regular;
- Day to day;
- Reasonable in all circumstances for the purpose of protecting the children concerned;
- Carried out by someone who is engaging in regulated activity relating to children.

Regulated activity still excludes family arrangements, and personal non-commercial arrangements.

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<sup>1</sup> Overnight work with children does not have to be done regularly to meet the definition of Regulated Activity

## **New Definition relating to adults.**

The new definition of Regulated Activity relating to adults no longer labels adults as “Vulnerable”, instead it identifies activities that, if any adult requires them, lead to that adult being considered vulnerable at that particular time. This means that the focus is on the activities/ services required by the adult and not on the setting in which the activity/service is received, or the personal characteristics or circumstances of the adult receiving the activities. There is no longer a requirement for a person to do the activities a certain number of times before they are engaging in Regulated Activity.

There are six categories of people who will fall within the new definition of regulated activity (and so will anyone who provides day to day management or supervision of those people). A broad outline of these categories is set out below.

### **(i) Providing Healthcare**

Any healthcare professional providing healthcare to an adult, or anyone who provides health care to an adult under the direction or supervision of a health care professional. Under the Protection of Freedoms Act 2012, the definition of Health Care is as follows:

- Health Care includes all forms of health care provided for individuals, whether relating to physical or mental health and also includes palliative care and procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition;
- A Health Care Professional is a person who is a member of a profession regulated by a body mentioned in section 25 (3) of the National Health Service Reform and Health Care Professions Act 2002.
- Any reference in this Part of this Schedule to health care provided by, or under the direction or supervision of, a health care professional includes a reference to first aid provided to an adult by any person acting on behalf of an organisation established for the purpose of providing First Aid.

### **(ii) Providing Personal Care**

Anyone who:

- Provides physical assistance with eating or drinking, going to the toilet, washing or bathing, dressing, oral care or care of the skin, hair or nails because of an adult’s age, illness or disability;

- Prompts and then supervises an adult who, because of their age, illness or disability cannot make the decision to eat or drink, go to the toilet, wash or bathe, get dressed or care for their mouth, skin, hair or nails without that prompting or supervision; or
- Trains, instructs or offers advice or guidance which relates to eating or drinking, going to the toilet, washing or bathing, dressing, oral care or care of the skin, hair or nails to adults who need it because of their age, illness or disability.

**(iii) Providing Social Work**

The provision by a social care worker of social work which is required in connection with any health care or social services to an adult who is a client or potential client.

**(iv) Assistance with General Household Matters**

The provision of assistance to an adult because of their age, illness or disability, if that includes managing the person's cash, paying their bills or shopping on their behalf.

**(v) Assistance in the Conduct of a Person's Own Affairs**

Anyone who provides various forms of assistance in the conduct of an adult's own affairs, for example by virtue of an enduring power of attorney.

**(vi) Conveying**

Anyone who transports an adult because of their age, illness, or disability either to or from their place of residence and a place where they have received, or will be receiving, health care, personal care or social care: or between places where they have received or will be receiving health care, personal care or social care. This will include Patient Transport Service drivers and assistants, hospital porters and Emergency Care Assistants and Ambulance Technicians.

From 10<sup>th</sup> September 2012, if you consider that a role is within the new definition of Regulated Activity, an Enhanced Access NI check must be carried out and a request made for the appropriate DBS Barred List check (For Children, Adults or both). Enhanced Access NI checks for work within regulated activity will tell you (where requested) if the person is on one of the DBS's Barred Lists.

**Why does Regulated Activity Matter?**

From 12<sup>th</sup> October 2009, two new Barred Lists were created, the Childrens' Barred List and the Adults' Barred List. These lists contain details of those individuals the DBS has decided it is appropriate to bar from working with children or vulnerable adults and those who are therefore prevented from working or volunteering with them. The DBS maintains these lists.

An organisation which knowingly allows a barred person to work in regulated activity will be breaking the law.

If you dismiss or remove someone from regulated activity, or you would have done had they not already left, because they appeared to pose a risk to

vulnerable groups including children, you are legally required to pass information about that individual to the DBS. It is a criminal offence not to do so. If you believe that an offence has been committed, you should pass the information to the police. Further information on the duty to refer to the DBS can be found on their website: <http://www.homeoffice.gov.uk/agencies-public-bodies/dbs/> Please contact the Employment Law Team, Human Resources, who will be able to advise.

### **b) Repeal of Controlled Activity**

The Controlled Activity Category will no longer exist from 10<sup>th</sup> September 2012. This category covered people who might have had less contact with vulnerable groups, including children, than people within Regulated Activity, for example, some people who deal with health records. Currently you can check whether those people working in Controlled Activity are barred; after 10<sup>th</sup> September 2012 you will not be able to do this.

### **c) Repeal of Registration and Continuous Monitoring**

The original intention of the Vetting and Barring Scheme was that anyone who wanted to work with vulnerable groups including children would need to register with the scheme and be continuously monitored for any new criminal records information. This never came into force and will not now be introduced. The Protection of Freedoms Act 2012 repeals those parts of the Safeguarding Vulnerable Groups (NI) Order 2007 which provided for registration and monitoring.

## **4 RESPONSIBILITIES OF BELFAST HEALTH AND SOCIAL CARE TRUST**

The Belfast Health and Social Care Trust is a Regulated Activity Provider (RAP) and is responsible for the management or control of regulated activity, paid or unpaid, and makes arrangements for people to work in that activity. The Trust is required to fully implement all the requirements of the SVGO legislation and VBS, as amended by the Protection of Freedoms Act 2012, as set out in the DHSSPS/DBS/ANI Guidance and Legislation.

The Trust is a Registered Body with Access NI and can access the services of ANI to obtain checks on prospective and current employees. As a Registered Body the Trust has a critical role in the management of any information disclosed.

The Trust's Recruitment and Selection Policy has been reviewed to ensure compliance with the requirements of VBS, as amended by the Protection of Freedoms Act 2012, as it relates to prospective employees to ensure that checks are carried out to ensure that members of staff are who they say they are, have the skills and qualifications they say they have, are registered with the appropriate regulatory body as necessary, have undergone appropriate pre employment health screening, that references are checked and that gaps in employment are questioned. The Trust will ensure that following recruitment, staff will be effectively managed, supervised, trained and appraised to ensure that they are carrying out their responsibilities in a diligent and compassionate way. In relation to students, placements and volunteers the Trust will ensure that the requirements of VBS, as amended, are undertaken in line with this Protocol.

The Trust's Disciplinary Policy has been reviewed and supplemented by guidance to ensure that the necessary referral requirements set out under the VBS are adhered to.

#### **4.1 SPECIFIC RESPONSIBILITIES**

##### **The Trust: -**

- must be a Registered Body with ANI and adhere to its Code of Practice and Explanatory Guide so that checks can be made against: Criminal Record Viewer, The Police National Computer and where appropriate information from Police Forces throughout the UK for any additional non-conviction material, including cases pending, which the Police consider relevant for Disclosure. The Trust has a written Statement of Intent which sets out its responsibilities for the correct handling and safekeeping of Disclosure information – attached as appendix 2
- must ensure that the appropriate arrangements are in place to ensure posts are identified as being regulated activity under the new definition and that the appropriate checks are made
- must not knowingly employ in a regulated activity or use as a volunteer a barred person
- must refer to the DBS any employee or volunteer in regulated activity who has been dismissed or no longer used because the Trust thinks they have harmed or pose a risk of harm to children or vulnerable adults

### **Line Managers:-**

- must ensure that they and their staff are familiar with this Protocol and the Guidance referred to and keep abreast of further developments
- must identify on the Trust's online advertisement request form – refer to appendix 3 – if a vacant post meets the definition of regulated activity and requires an appointee to be vetted
- must identify any staff who transfer on a permanent or temporary basis from a position that does not fall within the definition for regulated activity as appropriate to a post that does meet the definitions and ensure that these staff are vetted appropriately prior to commencement in the new position
- must ensure that an Access NI check is conducted for any staff returning from an employment break/unpaid leave
- must liaise with Human Resources staff in relation to any students/training positions/other individuals to ensure that vetting is conducted as appropriate
- must alert Senior Management and Employment Law Team within Human Resources Directorate to any incident which gives rise to concern or where allegations are made about an individual working with children/vulnerable adults. Advice and guidance on issues which may give rise to the referral of information to DBS will be provided by the Employment Law Team

### **Human Resources Staff:-**

- must ensure that they are fully conversant with and adhere to the requirements of this Protocol and associated guidance in the recruitment and placement of staff
- must ensure that they are conversant with and adhere to the requirements of this Protocol and associated guidance in relation to the referral of any staff to the DBS
- must provide guidance and support to Line Managers in the implementation of this Protocol
- must ensure that associated Policies – Disciplinary, Recruitment and Selection, Work Experience, Honorary Appointments, Employment Breaks– are kept under review to ensure compliance with this Procedure
- must ensure that there is adherence to the Statement of Intent for the management, handling and storage of completed application forms and disclosure certificates and that the Governance Arrangements set out in Section 6 of this protocol are satisfied



- must review the Protocol on an annual basis, and at earlier intervals where appropriate, to ensure it is reflective of any legislative or procedural changes
- Requesting Enhanced Disclosure Checks

In line with the Trust's Recruitment and Selection Policy managers are required to complete an Advertisement Request form in order to advertise a vacancy within the Trust and must indicate on the form if a pre-employment check is required under VBS - refer to appendix 3 of this procedure. This requirement also applies to the engagement of any volunteers or work placements within the Trust.

Applications for Enhanced Disclosures are made for applicants selected for appointment or transfer at the Trust's request or in line with mandatory requirements as appropriate. The application form used is a universal form for both DBS registration and EDC checks (see Appendix 5) and the application form must be signed by an approved signatory of the Trust – the Registered Body – and sent to ANI once the Applicant's identity has been verified. It should be noted that the Trust must indicate on the form that the post will involve working with children or vulnerable adults. It is only the nominated lead or countersignatories who can manage this Disclosure process and ensure that the necessary verification of the applicant's identification is carried out by the appropriate persons.

As a Registered Body the Trust must ensure that the Disclosure information is treated sensitively and confidentially and that it is protected from unauthorised access in line with its Statement of Intent and the ANI Code of Practice. All applicants and employees must be informed of this.

The Trust is required to make payment to ANI for the Disclosure Certificate and has an account with ANI to facilitate this. Both the Trust's signatory and the applicant receive copies of the Disclosure Certificate. ANI should process 90% of Enhanced Disclosures within 4 weeks.

It should be noted that sometimes applicants may seek to reuse their Disclosure Certificate as part of a separate recruitment exercise. The value of a Disclosure is directly linked to its contemporaneousness. Enhanced Certificates should not be reused because every application to see spent convictions or approved information should be countersigned by a registered person on the basis of a specific role or position.

- Outcome of Checks

On receipt of a Disclosure Certificate the Trust must ensure that the Statement of Intent and Code of Practice is complied with and only those staff entitled to see Disclosures in the course of their duty should have access. In exceptional circumstances the Police may provide additional information in a sealed envelope – this is only where the Police have identified a clear risk and such information must not be disclosed or discussed with the applicant. ANI will not be privy to the details of such information.

If it is confirmed that an individual's name is included on the barred lists they are disqualified from working in a regulated position and they will not be able to obtain DBS registration. If the individual is in the employment of the Trust and information is provided which indicates that there has been an issue of non-disclosure of previous offences by the employee then the appropriate action will be taken to investigate the matter under the Trust Disciplinary Procedure.

- Disputes and Disagreements

If an individual believes information disclosed about them is inaccurate they should follow the guidance set out at section 1.13 of the Guide to Access NI.

- Handling and Storage of Information

The Trust has a written Statement of Intent covering the correct handling and safekeeping of all documentation relating to an individual's disclosure information – appendix 2. It adheres to the ANI Code of Practice and guidance and its responsibilities under the Data Protection Act.

- Other Positions

Students, trainees, placements and other non employees assigned to regulated positions within the Trust require to be checked. The checks may be undertaken by the Trust or alternatively by the sponsoring organisation depending on specific arrangements in place. Special arrangements apply to students in NI undergoing professional training whereby the University/College in NI is responsible for undertaking the check prior to the commencement of training. Examples include the following:

- Medical and Dental – Queens University Belfast

- Nursing and Midwifery – Queens University Belfast and University of Ulster
- Allied Health Professionals to include Dietetics, Physiotherapy, Occupational Therapy, Speech and Language, Podiatry, Radiography – University of Ulster
- Clinical Psychology – Queens University Belfast
- Pharmacy
- Optometry
- Dental Nurses (BMC)
- NNEB (Child care course (BMC))

These arrangements do not apply to Universities or Colleges outside NI or to students who are employees. Responsibility for checks on such students remains with the Trust. All other placements should be arranged through the Honorary Contract process prior to the commencement of the placement.

- Employment Agencies - Arrangements will be put in place under the Trust's Safer Recruitment and Employment Framework to ensure that contracted agencies are compliant with the VBS Scheme as amended by the Protection of Freedoms Act 2012.
- Staff employed by Private Contractors – Arrangements will be put in place, in partnership with BSO to ensure that the relevant contractors are compliant with the VBS Scheme as amended and meet the associated costs where appropriate.
- Executive and non-executive members of Health and Social Services Trusts. The checks will be undertaken by the DHSSPS.
- In relation to school children on work experience there is no requirement to register but there must be adequate supervision and compliance with the appropriate work experience protocol.
- Applicants from Outside the UK/Overseas –ANI is unable to obtain overseas criminal records. It can only provide details of offences committed in the UK. The Trust can consider examining the website of the Police Force of the country of origin or contact the country's representative in the UK. It can ask those with overseas residence to apply for the equivalent of a disclosure, if available.

In relation to these groups, the Trust must ensure that appropriate checks are being carried out and ensure that the appropriate arrangements under VBS as amended are set out explicitly in any contract and that these are being adhered to. This should be reviewed on a regular basis.

## **6 REFERRALS TO DBS**

As a Regulated Activity Provider the Trust has a legal duty to refer information to the DBS in certain circumstances. With effect from 12 October 2009 a duty to share information has been in place under the Vetting and Barring Scheme and from this date employers, social services and professional regulators will have to notify the DBS of relevant information so that individuals who pose a threat to vulnerable groups can be identified and barred from working with these groups. DBS Referral Guidance has been developed and sets out the key elements of the new referral process, the circumstances under which a referral should be made, the legal responsibilities of employers and the main points of the law in relation to referrals.

The guidance is available at <http://www.homeoffice.gov.uk/agencies-public-bodies/dbs/services/dbs-referrals/> and should be referred to when dealing with any referral issues. Advice and guidance **must** be sought from the Employment Law Team in Human Resources when dealing with a referral issue.

In dealing with referrals there are two conditions both of which must be met to trigger a referral to the DBS:

A referral must be made to the DBS when a regulated activity provider, such as an employer or volunteer co-ordinator.

- 1) Withdraws permission for an individual to engage in regulated activity, or would have done so had that individual not resigned, retired, been made redundant or been transferred to a position which is not regulated activity; because
- 2) they think that the individual has:
  - engaged in relevant conduct;
  - satisfied the Harm Test; or
  - received a caution or conviction for a relevant offence

If both conditions have been met the information **must** be referred to the DBS

Definitions of these terms and guidance on the stage at which a referral should be made and the evidence to be provided are set out in detail in the guidance. The DBS Referral Form is appended as appendix 6 for information and Appendix 7 sets out the DBS Guidance on types of harm.

In relation to the referral of individuals who are engaged by the Trust through an employment agency or who are placed with the Trust, for example through a university placement, the Trust must ensure that it informs these organisations, fully cooperates with them and ensures that they make a referral as appropriate in line with the Guidance.

## **7 GOVERNANCE ARRANGEMENTS**

This protocol will be kept under review to ensure compliance with any future legislative requirements. It will be reviewed formally on an annual basis and at appropriate periods where legislative changes occur. Checking to ensure compliance is carried out by: -

- Seeking evidence from HR Co Director that the Recruitment and Selection and Disciplinary Policies have been reviewed in light of any legislative or Departmental guidance developments.
- Seeking evidence from the HR Co Director on a six monthly basis that the requirements for the vetting of prospective staff are being conducted in line with this Protocol and associated guidance. This will involve undertaking a sample of vetting conducted by the Trust's Recruitment team to ensure procedures are being followed.
- Seeking evidence from the HR Co Director on a six monthly basis that the process for referring any staff to the DBS has been conducted in line with this Protocol and associated guidance.
- Seeking evidence from the HR Co Director that any Contracts with Private Contractors and Employment Agencies are compliant with the SVG legislation and VBS (as amended) and that monitoring arrangements are in place to ensure same.
- Seeking evidence from the HR Co Director on a six monthly basis that all arrangements for Honorary Contracts are compliant with this protocol and associated guidance and that monitoring arrangements are in place to ensure same.

- The HR Co Director will ensure that the audit arrangements set out in the Safer Recruitment and Employment Framework are implemented and reported on to the HR User Forum and any recommendations are taken forward.

December 2012

## Appendices

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## CHANGES TO DISCLOSURE AND BARRING

On 10<sup>th</sup> September 2012 changes are being made to the Vetting and Barring Scheme which **will reduce** the number of AccessNI checks being undertaken by the Trust. These changes are designed to make the system more proportionate whilst still ensuring they continue to provide effective protection for those who need it.

These changes came about following a review of the Vetting and Barring Scheme, the outcome of which has informed a number of measures now in the Protection of Freedoms Act 2012, which has subsequently amended the Safeguarding Vulnerable Groups Order 2006, (NI) Order 2007.

### THREE KEY CHANGES IN SEPT

#### (1) Scaling back of Regulated Activity

Currently Regulated Activity (RA) covers over 9 million people across Northern Ireland, England and Wales. From September 2012 it will cover closer to 5 million. It is scaling back Regulated Activity to focus on work which involves close and unsupervised contact with vulnerable groups including children.

#### Definition of RA relating to children

- a) **Unsupervised activities** - teaching, training, instructing, caring for or supervising children, or providing advice/guidance on well-being, or driving a vehicle for children;
- b) **Work for a limited range of establishments** (specified places) with opportunity for contact. e.g. schools, children's homes, childcare premises, a children's hospital **but** not work by supervised volunteers in those places;

Work under (a) and (b) is Regulated Activity only if done regularly. Regularly means carried out by the same person frequently (once a week or more), or on 4 or more days in a 30 day period. The DHSSPSNI will shortly be providing statutory guidance about supervision to accompany the new definition of Regulated Activity.

- c) **Relevant personal care** - e.g. washing or dressing; or health care by, or supervised by a professional;
- d) **Registered childminding; and foster-care**

#### Definition of RA relating to adults

The new definition no longer labels any adult as 'vulnerable'. Instead it identifies activities that, if any adult requires them, lead to that adult being considered vulnerable at that particular time. (There is no longer a requirement to carry out activities a certain number of times under the adult definition).

- a) **Providing health care** - Any healthcare professional providing health care to an adult, or anyone who provides healthcare to an adult under the direction or supervision of a healthcare professional;
- b) **Providing personal care** – Assistance with washing, dressing, eating, drinking, toileting, oral care or care of the skin, hair or nails or teaching someone to do one of these tasks;
- c) **Providing social work** – provision by a social care worker of social work which is required in connection with any health services or social services;
- d) **Assistance with general household matters** – assistance with a person's cash, bills or shopping because of their age, illness or disability;
- e) **Assistance in the conduct of a person's own affairs** – i.e. enduring powers of attorney, or deputies appointed under the Mental Health Order;
- f) **Conveying** – Anyone who transports an adult because of their age, illness or disability to, from or between places where they receive healthcare, personal care or social work. This will include Patient Transport Services drivers and assistants, hospital porters and Emergency Care Assistants. This does not include friends, family or taxi drivers.



## (2) Repeal of Controlled Activity

The Controlled Activity category will no longer exist from September 2012. This category covered people, who might have had less contact with vulnerable groups including children, than people within Regulated Activity – for example some people who deal with records. At the moment, you can check whether those people working in Controlled Activity are barred; after 10<sup>th</sup> September 2012, you will not be able to.

## (3) Repeal of Registration and Continuous Monitoring

The original plan – in the Vetting and Barring Scheme – was that anyone who wanted to work with vulnerable groups including children would need to register with the Scheme and to be continuously monitored for any new criminal records information. This never came into force and we can now confirm that registration and monitoring will not be introduced.

## COMMON QUESTIONS & ANSWERS

### 1. Can an AccessNI check be carried out for a post that previously fell under the definition of Regulated Activity however does not meet the revised criteria?

Posts that previously met the criteria for Regulated Activity, however now do not meet the revised criteria, are not required to undertake an AccessNI check.

Employers will however, in these circumstances, have discretion to carry out an AccessNI check where they feel this is appropriate. It is important to note that these posts will no longer be eligible for barred list checks.

### 2. Could you explain the two-tier system of enhanced checks (with and without a barred list check) and how they will work in practice?

Those who fall within the new definition of Regulated Activity will be entitled to an AccessNI check and a barred list check. Those people who currently fall within the definition of Regulated Activity however will not meet the revised definition from 10<sup>th</sup> September 2012, will only be entitled to an AccessNI check but will not be eligible for a barred list check. As stated in question one above employers are not required to

carry out an AccessNI check on those who no longer fall within the revised definition of Regulated Activity.

### 3. Are cleaners and housekeepers working in a specified place (i.e. a children's home or children's hospital) still in Regulated Activity?

Yes. All staff working in a specified place who meet the definition of regular (once a week or more, or on 4 or more days in a 30 day period) meet the definition of Regulated Activity.

### 4. Do cleaners who do not work within a specified place fall within the revised definition of Regulated Activity?

No. Only staff who work in a specified place (schools, children's homes, childcare premises, a children's hospital) meet the revised definition of Regulated Activity.

As stated above, for posts that previously fell under the definition of Regulated Activity but will no longer from 10<sup>th</sup> September, employers can carry out an AccessNI check, however are not required to do so. They will however not be permitted to undertake a barred list check.

### 5. Supervised volunteers do not fall under the revised definition of Regulated Activity for children. Our volunteers are largely supervised however may occasionally have unsupervised access. Do they fall within the definition of Regulated Activity?

If a volunteer is always supervised then they do not meet the definition of Regulated Activity.

If a volunteer is unsupervised regularly and meet the definition of regularly (once a week or more, or on 4 or more days in a 30 day period) then they meet the definition of Regulated Activity.

If the frequency of them being unsupervised does not meet the definition of 'regularly' then they are not classed as being in a Regulated Activity post. It is important that managers ensure appropriate safeguards are in place to manage any perceived risks.

**6. Some of our staff go into adult's homes to cook their food and assist them to eat. Does this meet the definition of 'personal care' under point 2 above, in the adult definition, and therefore meet the definition of Regulated Activity?**

Physical assistance with eating or drinking, for example cutting up food and spoon feeding an adult who is unable to do so because of their age, illness or disability, would be in Regulated Activity. Teaching an adult to feed themselves, for example teaching someone to use adapted cutlery following a stroke, would also be in Regulated Activity.

Food preparation that does not include physically assisting an adult, for example preparing and serving a meal is not in Regulated Activity.

**7. After September will there be fewer teaching staff (who teach adults) in Regulated Activity?**

Yes. From September the only teaching that falls within the definition of Regulated Activity will be restricted to teaching related to personal care as defined above.

**8. What are the consequence of submitting ineligible AccessNI checks?**

Should an employer submit an unnecessary check for a post (i.e. request an AccessNI check with barred list check for a post that does not meet the new definition of Regulated Activity) then AccessNI may remove a registered body's status. In addition it leaves an employer open to challenge from the applicant.

**9. Are there any changes happening after September 2012?**

Yes. There will be additional changes in December 2012 and also during 2013/14. We will provide further information on these changes prior to their introduction.

In summary however the December 2012 change will involve the merging of the work of the CRB and ISA into a single new Non-Departmental Public Body. This will be called the Disclosure and Barring Service (DBS). The DBS will carry out the ISA's current functions in Northern Ireland and AccessNI will continue to provide a disclosure service for Northern Ireland.

During 2013/14 AccessNI will be introducing a new portable disclose service. This new service will allow

individuals to apply for a criminal record certificate only once and then, if they need a similar sort of check again, to reuse their existing certificate with their employer checking online to see if it is still up to date. This will avoid many repeat applications.

## WHAT IS NOT CHANGING

- Employers must continue to make appropriate referrals to the ISA/DBS
- Employers must not engage in Regulated Activity someone whom you know has been barred by the ISA
- Individuals who fall under the new definition of Regulated Activity will continue to be eligible for an enhanced disclosure with a barred list check.
- Individuals who fell under the old definition of Regulated Activity, but do not from 10th September 2012, will remain eligible for enhanced checks but without a barred list check.

## FURTHER INFORMATION

Further information on these changes can be obtained from the following webpage:

[www.homeoffice.gov.uk/disclosure-and-barring-leaflet](http://www.homeoffice.gov.uk/disclosure-and-barring-leaflet)

Any queries regarding this information note should be directed to the Recruitment and Selection Team who can provide further advice and guidance.

Marie Curran – 028 9504 8975  
Stephen Brady – 028 9504 8895  
Deborah Ireland – 028 9504 9089

Any queries concerning referrals to the ISA/DBS should be made to the Employment Law Team.

Geraldine Murray – 028 9504 906

## DEFINITION OF TERMS

Taken from: [www.homeoffice.gov.uk/disclosure-and-barring-leaflet](http://www.homeoffice.gov.uk/disclosure-and-barring-leaflet)

### 1. New Definition of Regulated Activity

The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 sets out the activities and work which are 'regulated activity', which a person who has been barred by the DBS must not do. We are scaling back on regulated activity to focus on work which involves close and unsupervised contact with vulnerable groups including children. Currently, regulated activity covers over 9 million people across Northern Ireland, England and Wales. From September, it will cover closer to 5 million, with proportionate reductions in Northern Ireland. The activities and work which are being taken out of regulated activity will still be eligible for enhanced Access NI checks (but they will no longer be eligible for barred list checks).

Regulated activity matters because:

- An organisation which knowingly allows a barred person to work in regulated activity will be breaking the law.
- If you dismiss or remove someone from regulated activity – or you would have done had they not already left – because they appeared to pose a risk to vulnerable groups including children, you are legally required to pass information about that to the DBS. It is a criminal offence not to do that. If you believe that an offence has been committed, you should pass the information to the police. For further information on the duty to refer to the DBS, please see <http://www.homeoffice.gov.uk/publications/agencies-public-bodies/dbs/dbs-referrals-guidance/>
- From 10<sup>th</sup> September, if you consider that a role is within the new definition of regulated activity, then if you ask the individual to apply for an enhanced Access NI check you should request the appropriate barred list check (for children, adults or both). Enhanced Access NI checks for work within regulated activity will tell you (where requested) if the person is on one of the DBS's barred lists. They do not generally include that information for work outside regulated activity.

### Summary of Changes to Regulated Activity

The full, legal definition of regulated activity is set out in Schedule 2 to the Safeguarding Vulnerable Groups (Northern Ireland ) Order 2007, as amended (in particular, by the Protection of Freedoms Act 2012).

Regulated activity still excludes family arrangements, and personal non-commercial arrangements.

### 1. Regulated activity relating to children

The amended definition of regulated activity comprises only:

- (i) Unsupervised activities: teaching, training, instructing, caring for or supervising children, or providing advice/ guidance on well-being, or driving a vehicle only for children;
- (ii) Work for a limited range of establishments ('specified places') with opportunity for contact: e.g. schools, children's homes, childcare premises, a children's hospital **but** not work by supervised volunteers in those places;

Work under (i) or (ii) is regulated activity only if done regularly. We will be providing statutory guidance about supervision to accompany the new definition of regulated activity.

- (iii) Relevant personal care, e.g. washing or dressing; or health care by, or supervised by, a professional;
- (iv) Registered Childminding; and foster-care.

## 2. Regulated activity relating to adults

The new definition of Regulated Activity relating to adults no longer labels adults as "Vulnerable", instead it identifies activities that, if any adult requires them, lead to that adult being considered vulnerable at that particular time. This means that the focus is on the activities/ services required, or the personal characteristics or circumstances or circumstances of the adult receiving the activities. There is no longer a requirement for a person to do the activities a certain number of times before they are engaging in Regulated Activity.

There are six categories of people who will fall within the new definition of regulated activity (and so will anyone who provides day to day management or supervision of those people). A broad outline of these categories is set out below.

### (vii) Providing Healthcare

Any healthcare professional providing healthcare to an adult, or anyone who provides health care to an adult under the direction or supervision of a health care professional. Please see the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, as amended by the Protection of Freedoms Act 2012, for further details about what is meant by health care and health care professionals.

### (viii) Providing Personal Care

Anyone who:

- Provides physical assistance with eating or drinking, going to the toilet, washing or bathing, dressing, oral care or care of the skin, hair or nails because of an adult's age, illness or disability;
- Prompts and then supervises an adult who, because of their age, illness or disability cannot make the decision to eat or drink, go to the toilet, wash or bathe, get dressed or care for their mouth, skin, hair or nails without that prompting or supervision; or
- Trains, instructs or offers advice or guidance which relates to eating or drinking, going to the toilet, washing or bathing, dressing, oral care or care of the skin, hair or nails to adults who need it because of their age, illness or disability.

### (ix) Providing Social Work

The provision by a social care worker of social work which is required in connection with any health care or social services to an adult who is a client or potential client.

### (x) Assistance with General Household Matters

The provision of assistance to an adult because of their age, illness or disability, if that includes managing the person's cash, paying their bills or shopping on their behalf.

(xi) Assistance in the Conduct of a Person's Own Affairs

Anyone who provides various forms of assistance in the conduct of an adult's own affairs, for example by virtue of an enduring power of attorney.

(xii) Conveying

Anyone who transports an adult because of their age, illness, or disability either to or from their place of residence and a place where they have received, or will be receiving, health care, personal care or social care: or between places where they have received or will be receiving health care, personal care or social care. This will include Patient Transport Service drivers and assistants, hospital porters and Emergency Care Assistants and Ambulance Technicians



## Access NI Policy Statement

As an organisation using Access Northern Ireland to help assess the suitability of applicants for positions of trust, the Belfast HSC Trust complies fully with AccessNI's Code of Practice regarding the correct handling, use, storage retention and disposal of Disclosure Applications and Disclosure information. It also complies fully with its obligations under the [Data Protection Act 1998](#) and other relevant legislation pertaining to the safe handling, storage, retention and disposal of Disclosure information.

### Storage and Access

Disclosure information is kept securely, in lockable, non-portable, storage containers with access strictly controlled and limited to those who are entitled to see it as part of their duties.

### Handling

In accordance with section 124 of the Police Act 1997, Disclosure information is only passed to those who are authorised to receive it in the course of their duties. We maintain a record of all those to whom Disclosures or Disclosure information has been revealed and it is a criminal offence to pass this information to anyone who is not entitled to receive it.

### Usage

Disclosure information is only used for the specific purpose for which it was requested and for which the applicant's full consent has been given.

### Retention

Once a recruitment decision has been taken, we do not keep Disclosure information for any longer than is necessary. Information will not be retained but destroyed once a decision, recruitment or otherwise has been made.

### Disposal

Once the retention period has elapsed, we will ensure that any Disclosure information is immediately destroyed by secure means i.e. by shredding, pulping or burning. While awaiting destruction, Disclosure information will not be kept in any unsecured receptacle (e.g. waste-bin or confidential sack). We will not keep any photocopy or other image of the Disclosure or any copy or representation of the contents of a Disclosure or any other relevant non-conviction information supplied by police but not included on the Disclosure. However, despite the above, we may keep a record of the date of issue of a

Disclosure, the name of the subject, the type of Disclosure requested, the position for which the Disclosure was requested, the AccessNI unique reference number of the Disclosure Certificate and the details of the recruitment decision taken.



BELFAST HSC TRUST JOB ADVERTISEMENT REQUEST (REQUISITION)				HR REQ No(s).
NB: Form will not be processed unless all boxes fully completed				
Title of Post				
Specialty/Service Area		Location		
Band Please select band	Hours per week/times	Directorate Please select Directorate	Contract Type <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	
Source of Funding <input type="checkbox"/> New Post <input type="checkbox"/> Replacement of fully funded Post <input type="checkbox"/> Other Funds e.g. Maternity For any new post or funded posts through research & charitable please provide details: _____ _____				
Cost Centre	Size of team which post is part of?	How long has the post been vacant?		
How is the service being covered without this post? In cases where the service is covered by backfill, identify type and extent: _____ _____				
Has the redeployment of resources from other areas within/outside the Directorate been considered to cover the post? <input type="checkbox"/> Yes <input type="checkbox"/> No Consequence of not filling the post: _____				
Budget position NET OF ALL SAVINGS at end of Month (specify)		Position at Specialty/Service area level (under/overspent):		
_____		£ _____		
Permanent Post <input type="checkbox"/> Yes	Name of Person(s) being Replaced: _____	Temporary Post <input type="checkbox"/> Yes	Reason for Cover: _____	
Hours of previous postholder: _____		Name of Person cover required for: _____		
Band of previous postholder: Please select band		Start Date: _____	Duration of Cover: _____	
Waiting List (12 months) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent Bank Please tick all that apply.		Does this post require applicants to undertake an AccessNI check? (Please refer to the POCVA Policy) <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Enhanced Disclosures</b> are used mainly for positions that involve contact with children or vulnerable adults. The type of work will involve <b>regulated activity</b> (amended definition from 10 <sup>th</sup> September 2012).		
Advertisement to be placed in: (Please note that if a waiting list is currently in place then the post will be filled from this) <input type="checkbox"/> Belfast Telegraph <input type="checkbox"/> Trustwide Internal Trawl* <input type="checkbox"/> Limited Internal Trawl* <input type="checkbox"/> Job Market <input type="checkbox"/> HSCRecruit (Online) <input type="checkbox"/> Professional Journal (Please specify) _____ <b>ALL VACANCIES WHICH ARISE WILL NORMALLY BE ADVERTISED EXTERNALLY. *PLEASE CONTACT THE RECRUITMENT TEAM FOR ELIGIBILITY FOR INTERNAL TRAWLS.</b>				
Chairperson/Contact: _____		Contact Tel: _____		
Authorised by:				
Manager (PRINT): _____	Signed: _____	Date: _____		
Director (PRINT): _____	Signed: _____	Date: _____		
Directorate Accountant (All Posts)/Finance Director (New posts only) (PRINT): _____				
Signed: _____		Date: _____		
Please return your Signed Advertisement Request Form, along with an electronic Word Version of the Job description and specification to the HR Dept.				



Pre-Employment Risk Assessment Form

To be completed by the Chair of the Interview Panel or the Recruiting Manager using **BLACK** ink and **block capitals**

**Please note: Failure to complete all sections will result in a delay in completing the assessment**

<b>Trust / Employer: Belfast HSC Trust</b>	<b>Job Reference Number:</b>
<b>Service Group:</b>	<b>Location:</b>
<b>Position Applied for:</b>	<b>Contract hours:</b>

**This position may or will involve the following Activities, Hazards and Exposures (please tick Yes or No)**

<b><i>These guidance notes will assist managers in the accurate completion of the pre-employment risk assessment form. Further information and advice, if required, can be obtained from the Occupational Health Service.</i></b>		<b>YES</b>	<b>NO</b>
<b>Patient /Client contact</b>	This applies to staff who provide direct clinical ( 'hands on' ) care/treatment to patients /clients		
<b>Non-clinical patient contact</b>	This applies to staff who have contact with patients/clients but do not provide care/treatment.		
<b>No patient contact</b>	This applies to staff who do not have direct contact with patients/clients		
<b>Exposure Prone Procedures (EPP's)</b>	Where there is a risk that an injury to the worker may result in exposure of the patient's open tissues to the blood of the worker. These procedures include those where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissue (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. (If in any doubt, please contact Occupational Health for further advice)		
<b>Contact with blood / body fluid / body tissue</b>	Those workers who do not fall into the above category, but whose daily work may bring them into contact, with blood / body fluid / body tissue.		
<b>Driving (except to and from work)</b>	Those workers whose employment requires them to transport by motorised vehicle, patients or supplies on behalf of the organisation.		

<p><b>Manual Handling / postural demands</b></p>	<p>This includes patient and non-patient handling, lifting, carrying and lowering, repetitive bending or twisting, prolonged standing, or maintaining an awkward posture.</p>		
<p><b>Exposure to potentially violent / aggressive behaviour / verbal abuse.</b></p>	<p>This may include staff who are required to work with or in the following areas - children, elderly care, mental health, intensive care and emergency departments.</p>		
<p><b>Display Screen Equipment user</b></p>	<p>This involves continuous periods of one hour or longer on most working days where the worker has little or no discretion on when or whether to use the screen for their work.</p>		
<p><u>Food preparation</u></p>	<p>Those staff employed directly in the production and preparation of foodstuffs. This <b>does not</b> include staff who serve prepared food and drink to patients.</p>		
<p><b>Exposure to agents requiring health surveillance identified by COSHH **</b></p>	<p>Agents requiring health surveillance under COSHH regulations would for example include Glutaraldehyde, Photographic fixer/developer, Asbestos, Wood Dust, Latex particularly latex gloves, Isocyanates, Epoxy resins, Solder.  <b>Possible carcinogens:</b> May include employees who 'manufacture', mix or administer drugs or constituents, as indicated by the data sheets.                   A person would be considered to be 'exposed' whenever there is the likelihood of regular direct or indirect exposure to agents at work, regardless of the level.</p>		
<p><b>Other **</b>                  e.g., heights, confined spaces, noise, night worker, on-call, working alone / unsupervised.</p>	<p><u>Heights</u> - where the job may require the person to work at two metres above floor level, or less if there are factors that may increase the likelihood of a fall, or the risk of serious injury.   <u>Confined spaces</u> - where the job involves entering small areas with breathing apparatus.   <u>Noise</u> - exposure to sound at levels likely to cause damage to hearing, when daily exposure, averaged over an 8-hour period, exceeds 80dB(A). If, in any doubt please contact the Occupational Health Services for further advice.   <u>Hand Arm Vibration</u> – exposure to hand transmitted vibration above the action value of 2.5 m/s<sup>2</sup> A(8)   <u>Night worker</u> - employees who work between the hours of 23.00 and 06.00 hours and who should be offered health assessments before starting to work nights, and on a regular basis (i.e. 2 yearly), whilst continuing to work nights.</p>		

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Position: \_\_\_\_\_

Contact no: \_\_\_\_\_

**BHSCT SVG Protocol Interim Guidance-V2\_May 13**

## Overview of Disclosure and Barring Requirements from 10<sup>th</sup> September 2012

Definition of Regulated Activity (entitled to an Access NI check and a Barred List check)	Examples of Posts Covered
<p><b>CHILDREN1</b></p> <p><b>a) Unsupervised Activities</b> – teaching, training, instructing, caring for or supervising children, or providing advice/guidance on well-being, or driving a vehicle for children;</p> <p><b>b) Work for a limited range of establishments</b> – (specified places) with opportunity for contact, e.g. schools, children’s homes, childcare premises, a children’s hospital <b>but</b> not work by supervised volunteers in those places;</p> <p>Work under (a) and (b) is regulated activity only if done regularly. Regularly means carried out by the same person frequently (once a week or more), or on 4 or more days in a 30 day period, or overnight. The DHSSPSNI statutory guidance about supervision should be referred to at Appendix 5.</p> <p><b>c) Relevant personal care</b> – e.g. washing or dressing; or health care by, or supervised by a professional.</p> <p><b>d) Registered childminding; and foster-care</b></p>	<ul style="list-style-type: none"> <li>• All staff who work <b>regularly</b> in a specified place – This will include support services, admin as well as social care staff.</li> </ul> <p>Any of the following posts where the work involves children:</p> <ul style="list-style-type: none"> <li>• All Social Care Posts</li> <li>• All Nursing and Midwifery</li> <li>• All Medical and Dental</li> <li>• All Allied Health Professionals</li> <li>• Patient Transport Drivers who transport children</li> <li>• Art and Music Therapists</li> <li>• Trust Chaplains</li> </ul>
<p><b>ADULT</b></p> <p><b>a) Providing health care</b> – Any healthcare professional providing health care to an adult, or anyone who provides healthcare to an adult under the direction or supervision of a healthcare professional;</p> <p><b>b) Providing personal care</b> – Assistance with washing, dressing, eating, drinking, toileting, oral care or care of the skin, hair or nails or teaching someone to do one of these tasks;</p> <p><b>c) Providing social work</b> – provision by a social care worker of social work which is required in connection with any health services or social services;</p> <p><b>d) Assistance with general household matters</b> – assistance with a person’s cash, bills or shopping because of their age, illness or disability;</p> <p><b>e) Assistance in the conduct of a person’s own affairs</b> – i.e. powers of attorney, or deputies appointed under the Mental Health Order;</p> <p><b>f) Conveying</b> – Anyone who transports an adult because of their age, illness or disability to, from or between places where they receive healthcare, personal care or social work. This will include Patient Transport Services drivers and assistants, hospital porters and Emergency Care Assistants. This does not include friends/family/taxi drivers.</p>	<ul style="list-style-type: none"> <li>• All Social Care Posts</li> <li>• All Nursing and Midwifery</li> <li>• All Medical and Dental</li> <li>• All Allied Health Professionals</li> <li>• Patient Transport Drivers and Assistants</li> <li>• Home Care Workers</li> <li>• Trust Hairdressers</li> <li>• Porters</li> <li>• Art &amp; Music Therapists</li> <li>• Trust Chaplains</li> </ul>

## OUT OF SCOPE

The following are examples of posts that **no longer** meet the definition of regulated activity (this list is not exhaustive):

- Domestic staff who do not work in a specified place (children's homes, child care premises, children's hospitals)<sup>2</sup>
- Maintenance staff who work in a specified place but not regularly (once a week or more or on 4 days or more in a 30 day period)<sup>2</sup>
- Director/Senior Executive Positions
- Maintenance staff who do not work in a specified place
- Catering/ Laundry workers or other similar support services roles
- All admin & clerical (with the exception of those working in a specified place)
- Volunteers supervised at reasonable levels

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1 *A Child is any person who has not attained the age of 18 years*

2 *Posts that previously fell within the definition of regulated activity but no longer meet the definition **no longer** require an Access NI check. However the Trust can undertake an Access NI check if they so wish. It is important to note that the Trust is no longer permitted to undertake a barred list check for these posts.*

## Statutory Guidance: Regulated Activity (Children) – Supervision of Activity with Children which is Regulated Activity when Unsupervised

1. This document fulfils the duty in legislation<sup>23</sup> that the Secretary of State must publish statutory guidance on supervision of activity by workers with children, which when unsupervised is regulated activity. This guidance applies in England, Wales and Northern Ireland. It covers settings including but not limited to schools, childcare establishments, FE colleges, youth groups and sports clubs.
2. For too long child protection policy has been developed in haste and in response to individual tragedies, with the well-intentioned though misguided belief that every risk could be mitigated and every loophole closed. The pressure has been to prescribe and legislate more. This has led to public confusion, a fearful workforce and a dysfunctional culture of mistrust between children and adults. This Government is taking a different approach.
3. We start with a presumption of trust and confidence in those who work with children, and the good sense and judgement of their managers. This guidance applies when an organisation decides to supervise with the aim that the supervised work will not be regulated activity (when it would be, if not so supervised). In such a case, the law makes three main points:
  - There must be supervision by a person who is in regulated activity<sup>4</sup>;
  - The supervision must be regular and day to day; and
  - The supervision must be “reasonable in all the circumstances to ensure the protection of children”.

The organisation must have regard to this guidance. That gives local managers the flexibility to determine what is reasonable for their circumstances.

While the precise nature and level of supervision will vary from case to case, guidance on the main legal points above is as follows:

4. Supervision by a person in regulated activity/ regular and day to day: Supervisors must be in regulated activity themselves<sup>5</sup>. The duty that supervision must take place “on a regular basis” means that supervision must not, for example, be concentrated during the first few weeks of activity and then tail off thereafter, becoming the exception not the rule. It must take place on an ongoing basis, whether the worker has just started or has been doing the activity for some time.
5. Reasonable in the circumstances: within the Statutory Duty, the level of supervision may differ, depending on all the circumstances of a case. Organisations should consider the following factors in deciding the specific level of supervision the organisation will require in an individual case:
  - Ages of the children, including whether their ages differ widely;
  - Whether or not other workers are helping to look after the children;

<sup>2</sup> Safeguarding Vulnerable Groups Act 2006, amended by the Protection of Freedoms Act 2012: Schedule 4, paragraph 5A: guidance must be “for the purpose of assisting” organisations “in deciding whether supervision is of such a kind that” the supervisee is not in regulated activity.

<sup>3</sup> Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, Schedule 2, paragraph 5A, is as above on guidance on “supervision” for Northern Ireland.

<sup>4</sup> If the work is in a specified place such as a school, paid workers remain in regulated activity even if supervised.

<sup>5</sup> From 2013-14, the Government plans to commence a statutory duty on an organisation arranging regulated activity (under the 2006 Act or 2007 Order, both as amended) to check that a person entering regulated activity is not barred from regulated activity; and plans to commence a stand-alone barring check service by the new Disclosure and Barring Service.

- The nature of the individual's work (or, in a specified place such as a school, the individual's opportunity for contact with children);
- How vulnerable the children are (the more they are, the more an organisation might opt for workers to be in regulated activity);
- How many workers would be supervised by each supervising worker.

6. In law, an organisation will have no entitlement to do a barred list check on a worker who, because they are supervised, is not in regulated activity.

#### EXAMPLES

Volunteer, in a specified place

Mr Jones, a new volunteer, helps children with reading at a local school for two mornings a week. Mrs Jones is generally based in the classroom, in sight of the teacher. Sometimes Mr Jones takes some of the children to a separate room to listen to them reading, where Mr Jones is supervised by a paid classroom assistant, who is in that room most of the time. The teacher and classroom assistant are in regulated activity. The head teacher decided whether their supervision is such that Mr Jones is not in regulated activity.

Volunteer, not in a specified place

Mr Wood, a new entrant volunteer, assists with the coaching of children at his local cricket club. The children are divided into small groups, with assistant coaches such as Mr Wood assigned to each group. The head coach oversees the coaching, spends time with each of the groups, and has sight of all the groups (and the assistant coaches) for most of the time. The head coach is in regulated activity. The club managers decide whether the coach's supervision is such that Mr Wood is not in regulated activity.

Employee, not in a specified place

Mrs Shah starts as a paid activity assistant at a youth club. She helps to instruct a group of children, and is supervised by the youth club leader who is in regulated activity. The youth club managers decide whether the leader's supervision is such that Mrs Shah is not in regulated activity.

In each example, the organisation uses the following steps when deciding whether a new worker will be supervised to such a level that the new worker is not in regulated activity:

- Consider whether the worker is doing work that, if unsupervised, would be regulated activity. If the worker is not, the remaining steps are unnecessary.
- Consider whether the worker will be supervised by a person in regulated activity, and whether the supervision will be regular and day to day, bearing in mind paragraph 4 of this guidance;
- Consider whether the supervision will be reasonable in all the circumstances to ensure the protection of children, bearing in mind the factors set out in paragraph 5 of this guidance;

And if it is a specified place, such as a school:

- Consider whether the supervised worker is a volunteer<sup>6</sup>.

Department for Education/ Department of Health, Social Services and Public Safety (Northern Ireland),  
September 2012

<sup>6</sup> A volunteer is: in England and Wales, a person who performs an activity which involves spending time, unpaid (except for travel and other approved out-of-pocket expenses), doing something which aims to benefit someone (individuals or groups) other than or in addition to close relatives; in Northern Ireland, a person engaged, or to be engaged, in an activity for a non-profit organisation or person which involves spending time unpaid (except for travel and other approved out-of-pocket expenses) doing something which amounts to a benefit to some third part other than, or in addition to, a close relative.



# Application form: Standard / Enhanced Disclosure ISA Registration

**About this form**

This form can be used to apply for an AccessNI Standard or Enhanced disclosure and/or to register with the Independent Safeguarding Authority [ISA]. If you are applying for an AccessNI disclosure and for ISA registration on this form, it must be for the same position - if not, two application forms must be completed.

*If you require help completing this form you can visit our website on [www.accessni.gov.uk](http://www.accessni.gov.uk) where you will find step-by-step instructions in our Guidance. Alternatively you can call our helpline on (028) 9025 9100 or speak to the person who asked you to complete the form.*

Please complete this application form in CAPITAL letters and use black ink. Applicants must complete Parts B, C, D, E, F and G and return the form to whoever sent it to them for completion of Parts A, H, I and J.



Completed forms should be posted to: **AccessNI,**  
PO Box 1085  
Belfast  
**BT5 9BD**

Failure to complete the form correctly may result in a delay or the form being returned unprocessed.

**Data Protection**

Information on this form will be treated in confidence. AccessNI is registered with the Information Commissioner. Data supplied by you on this form will be processed in accordance with the provisions of the Data Protection Act 1998. The full protection statement is set out in section 1,10 of our Guidance.

*PLEASE WRITE CLEARLY IN THE BOXES PROVIDED (Continuation sheets are available from [www.accessni.gov.uk](http://www.accessni.gov.uk)).*

AccessNI Reference             (AccessNI use only)

**PART A Service required - cross 1 box only**

A1 Standard (£26)  Enhanced (£30)  Enhanced / ISA (£58)  ISA only (£58)

A2 Registered Body Name

A3 Registered Body No.

A4 Counter Signatory No.

For AccessNI use only

**PART B** Applicant's details

B1 Title Mr  Mrs  Miss  Ms  Other   
*If 'Other' please give details*

B2 Surname

B3 Forename(s)

B4 Name usually known by

B5 Surname at birth (if different)   
 used until  /  /

B6 Any other surname(s) used? No  Yes  *If 'Yes', please complete F1, if 'No' go to B7*

B7 Any other forename(s) used? No  Yes  *If 'Yes', please complete F5, if 'No' go to B8*

B8 Gender Male  Female

B9 Date of birth  /  /

B10 Place of birth - Town   
 Country

B11 National insurance number

B12 Driving licence number

B13 Do you hold a valid passport? No  *If No, go to B17.* Yes  *If Yes, complete B14, B15 and B16.*  
s

B14 Passport number

B15 Nationality

B16 Country of issue

B17 Do you have an ISA registration number? No  *If No, go to B19.* Yes  *If Yes, complete B18.*

B18 ISA registration number

B19 Do you have a Scottish Vetting & Barring number? No  *If No, go to B21.* Yes  *If Yes, complete B20.*

B20 Scottish Vetting & Barring number

B21 Preferred contact number

**PART C** Application for Registration with ISA

C1 Are you applying for registration with ISA? No  *If No, go to Part D.* Yes  *If Yes, complete C2 - C5.*

C2 Do you intend to work, paid or unpaid, with (Cross all that apply) Children  Vulnerable Adults

C3 Do you intend to work, paid or unpaid, in controlled activity with (Cross all that apply) Children  Vulnerable Adults

C4 Are you applying as a free of charge volunteer? No  Yes   
*By placing X in the Yes box at C4 I understand that I may be liable for payment at a later date should my employment status change.*

C5 Security information



**PART D Applicant's current and delivery address**

Please give details of your current address. This is the address to which all correspondence will normally be sent.

D1 Current address

D2 Town/City

D3 County

D4 Country

D5 Postcode

D6 Lived at this address since / /

Please give details of a preferred Delivery Address (if different from above).

D7 Delivery address

D8 Town/City

D9 County

D10 Country

D11 Postcode

**PARTE Address history**

If you have lived at the address at D1-D4 for less than 5 years please provide details of all your previous address(es) and dates of residence for the last 5 years. There must be no gaps in the dates; overlapping dates are acceptable. Please start with the most recent address and work backwards.

If necessary, please use the approved Address Continuation Sheet - this is downloadable at [www.accessni.gov.uk](http://www.accessni.gov.uk).

E1 Address

E2 Town/City

E3 County

E4 Country

E5 Postcode

E6 Lived at this address from / /  to / /

E7 Address

E8 Town/City

E9 County

E10 Country

E11 Postcode

## PART F Names history

This Section should only be completed if you have answered Yes to questions B6 or B7. You must provide details of your previous name(s), along with dates these names were used. There must be no gaps in the dates; overlapping dates are acceptable. Please use an additional page if necessary, clearly writing your current name at the top of the page.

F1 Previous surname

F2 date used from  /  /  to  /  /

F3 Previous surname

F4 date used from  /  /  to  /  /

F5 Previous forename

F6 date used from  /  /  to  /  /

F7 Previous forename

F8 date used from  /  /  to  /  /

**Once you have completed Part F, please return to B8 to continue with this Form.**

## PART G Declaration by Applicant

By signing the applicant declaration box I confirm that the information that I have provided in support of this application is complete and true and I understand that knowingly to make a false statement for this purpose may be a criminal offence.

G1 Do you have any convictions? No  Yes

Signature of applicant (please sign in box)

G3 Date of signature

Name (in CAPITALS)

Information you have supplied on this form, and any other additional information you have supplied in support of this application, may be passed to other Government organisations and law enforcement agencies.

**You must now return this form to the person who asked you to complete it**

For AccessNI use only

### PARTH Registered Body information

H1 Is the applicant applying for an AccessNI disclosure? No  If No, go to H7. Yes  If Yes, continue from H2.

H2 Position applied for

H3 Organisation Name

H4 Will the work be carried out at the home of the applicant? No  Yes

H5 Is the disclosure required for the purposes of asking an exempted question? No  Yes

H6 Is the disclosure required for a prescribed purpose? No  Yes

H7 Are you entitled to know if the applicant is registered to work with children? No  Yes

H8 Are you entitled to know whether the applicant is registered to work with vulnerable adults? No  Yes

H9 Have you established the true identity of the applicant by examining a range of documents as set out in AccessNI Guidance, and verified the information provided in Parts B, C, D, E & F? No  Yes


H10 Application type: New post holder  Existing post holder  Re-check of existing post holder

H11 Your reference Number

### PARTI Payment

11 Method of Payment Account  Card  Cheque  Postal Order  No Payment (Volunteer)

12 If paying by cheque, please complete the cheque number.

If paying by card, complete the card details below: 

13 Card number

14 Start date  /  End date  /

15 Issue number  (Maestro only)

16 Card security code

17 Name on card

18 Signature on card

19 Date of signature

### PARTJ Declaration

I confirm that the requisite documentation and information has been supplied and checked in accordance with AccessNI Guidance. I declare that the information I have provided in support of the application is complete and true and understand that knowingly to make false statement for this purpose may be a criminal offence.

## Factsheet 1: Employers and Volunteer Managers - when to make a referral to the Disclosure Barring Service (DBS)

• V2.0 - Dec 2012

### Purpose

This factsheet provides general guidance on when an employer of people who work (paid or unpaid) with children or vulnerable adults is required to make a referral to the DBS.

### What is a referral?

A referral is information regarding a person working in regulated activity with children or vulnerable adults which notifies us of concerns that harm or risk of harm has occurred to a child or vulnerable adult. A referral is made on the DBS Referral Form and is usually provided to the DBS by an employer or volunteer manager.

**For more detailed information see the DBS Referral Guidance and the Referral Form on the DBS website: [www.homeoffice.gov.uk/DBS](http://www.homeoffice.gov.uk/DBS) or call the DBS Helpline on 01325 953 795.**

### When to refer - specifics

The Safeguarding Vulnerable Groups Act (SVGA) 2006 and Safeguarding Vulnerable Groups (Northern Ireland) Order (SGVO) 2007, place a duty on employers of people working with children or vulnerable adults to make a referral to the DBS in certain circumstances. This is when an employer has **dismissed or removed** a person from working with children or vulnerable adults (or would or may have if the person had not left or resigned etc.) because the person has:

1. Been cautioned or convicted for a relevant offence; or
2. Engaged in relevant conduct in relation to children and/or vulnerable adults [i.e. an action or inaction (neglect) that has harmed a child or vulnerable adult or put them at risk of harm]; or
3. Satisfied the Harm Test in relation to children and/or vulnerable adults. [i.e. there has been no relevant conduct (i.e. no action or inaction) but a risk of harm to a child or vulnerable adult still exists].

#### 1. Caution or conviction for a relevant offence

If an employee who works with children or vulnerable adults in regulated activity has been cautioned or convicted for a relevant offence the employer must make a referral to the DBS. This should be done as soon as the employer is aware of the caution or conviction.

A relevant offence is a serious offence that will, subject to consideration of representations where permitted, automatically bar a person from working with children or vulnerable adults. Relevant offences are defined in secondary legislation. The DBS has a plain English version of relevant offences in Factsheet 5 on its website.

## Factsheet 1: Employers and Volunteer Managers - when to make a referral to the Disclosure and Barring Service (DBS)

### 2 or 3. Relevant conduct or harm test is satisfied

An employer or volunteer manager must make a referral to the DBS if the following criteria have been met:

- They have dismissed or removed the person from working with children or vulnerable adults (or would or may have done so if they had not left or resigned etc.); because
- The person has engaged in relevant conduct; or the Harm Test is satisfied.

A referral should not be made when an allegation is first made. The employer must first undertake an investigation and evidence gathering in order to establish if the allegation has foundation. Without evidence or information for the DBS to consider, many allegations will be quickly closed down as there will be no basis on which the DBS can proceed.

A referral should be made when the employer has gathered information and evidence to support the allegation and decided that the criteria for making a referral to the DBS has been met.

### Points to note

- If you suspect that a crime has been committed you should contact the Police.
- The DBS has no investigatory powers and relies upon the evidence provided with referrals and any other evidence that it may gather.
- It is crucial that employers do not make a referral to the DBS without providing supporting evidence. The DBS Referral Form details the information you should provide if you have it.
- Employers should, as far as possible, complete their investigations (even if the person has left their employment). This will ensure that the DBS has all available information and evidence on which to base its decision.
- If additional relevant information becomes available to an employer after making a referral, this should also be provided to the DBS.
- In all cases, the referral should be made on the DBS Referral Form and posted to the DBS enclosing all relevant information that the employer holds.

### DBS contacts

Helpline: 01325 953 795  
 Website: [www.homeoffice.gov.uk/DBS](http://www.homeoffice.gov.uk/DBS)  
 Email: [dbsdspatchteam@db.s.gsi.gov.uk](mailto:dbsdspatchteam@db.s.gsi.gov.uk)

Post: Disclosure and Barring Service  
 Post Office Box 181  
 Darlington  
 DL1 9FA



# Disclosure and Barring Service Referral Form

*Please refer to completing the referral form guidance whilst completing this document*

## Part 1: Details of the person you are referring

<p><b>A Personal information</b></p> <p>Title                  Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/>                  Other title <input style="width: 100%;" type="text"/></p> <p>Surname  <input style="width: 100%;" type="text"/></p> <p>Forename(s)  <input style="width: 100%;" type="text"/></p> <p>Date of birth  <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/>  <small>D D M M Y Y Y Y</small></p> <p>Or age if date of birth is not known <input style="width: 50%;" type="text"/></p> <p>Previous names and / or alias dates of birth  <input style="width: 100%; height: 50px;" type="text"/></p> <p>Gender                  Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>Nationality  <input style="width: 100%;" type="text"/></p> <p>National Insurance Number  <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></p>	<p><b>B Contact details of the person you are referring</b></p> <p>Contact Address  <input style="width: 100%; height: 100px;" type="text"/></p> <p>Post Code  <input style="width: 40px;" type="text"/><input style="width: 40px;" type="text"/><input style="width: 40px;" type="text"/><input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/><input style="width: 40px;" type="text"/></p> <p>Country  <input style="width: 100%;" type="text"/></p> <p>Home telephone  <input style="width: 100%;" type="text"/></p> <p>Mobile number  <input style="width: 100%;" type="text"/></p> <p>Work telephone (<i>if still working</i>)  <input style="width: 100%;" type="text"/></p> <p>Email address  <input style="width: 100%;" type="text"/></p>
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<p><b>C Address history (<i>most recent first</i>)</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 70%; border-bottom: 1px solid black;">Address</th> <th style="width: 15%; border-bottom: 1px solid black;">Date from</th> <th style="width: 15%; border-bottom: 1px solid black;">Date to</th> </tr> <tr> <td style="height: 100px;"></td> <td></td> <td></td> </tr> </table>	Address	Date from	Date to			
Address	Date from	Date to				

<p><b>D Professional registration (<i>if applicable</i>)</b></p> <p>Professional regulator  <input style="width: 100%;" type="text"/></p> <p>Registration number  <input style="width: 100%;" type="text"/></p>	<p><b>E Teacher reference (<i>if applicable</i>)</b></p> <p>Teachers pension number England and Wales  <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></p> <p><b>F CRB Disclosures</b></p>
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# Disclosure and Barring Service Referral Form

<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <p><b>Date of registration</b></p> <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 8px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 8px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">D</td> <td style="font-size: 8px;">D</td> <td></td> <td style="font-size: 8px;">M</td> <td style="font-size: 8px;">M</td> <td></td> <td style="font-size: 8px;">Y</td> <td style="font-size: 8px;">Y</td> <td style="font-size: 8px;">Y</td> <td style="font-size: 8px;">Y</td> </tr> </table>			/			/					D	D		M	M		Y	Y	Y	Y	<p><b>CRB Disclosure Number (if known)</b></p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
		/			/																
D	D		M	M		Y	Y	Y	Y												

**Part 2: Qualifications and training history of the person you are referring**

<b>G</b>	<p><b>Qualifications (please continue on a separate sheet if required)</b></p> <p><i>Title of qualification</i></p>	<p><i>Date of certificate</i></p>

<b>H</b>	<p><b>In service training / other training / courses attended (please continue on a separate sheet if required)</b></p> <p><i>Details of training</i></p>	<p><i>Date attended</i></p>



# Disclosure and Barring Service Referral Form

## Part 3: Details of the work carried out by the person you are referring

<p><b>I About their role</b></p> <p><b>Role Title</b></p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p><b>Type of role</b></p> <p>Paid <input type="checkbox"/>      Voluntary <input type="checkbox"/></p> <p><b>Date they started working / volunteering in the above role</b></p> <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> <p><b>Date they ceased working / volunteering in the above role</b></p> <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td>D</td><td>D</td><td>/</td><td>M</td><td>M</td><td>/</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> <p><b>How did they leave or were removed from the role?</b></p> <p>Dismissed <input type="checkbox"/>      Resigned <input type="checkbox"/>      Retired <input type="checkbox"/></p> <p><b>Other (please specify)</b></p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p><b>Was the role held by the person you are referring 'regulated activity' with:</b></p> <p>Children <input type="checkbox"/>      Vulnerable Adults <input type="checkbox"/>      Both <input type="checkbox"/></p> <p><b>Is the person still employed by you?</b></p> <p>Yes <input type="checkbox"/>      No <input type="checkbox"/></p> <p><b>If "Yes" to what role has the person been moved?</b></p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p><b>To your knowledge, has the person ever worked in Scotland?</b></p> <p>Yes <input type="checkbox"/>      No <input type="checkbox"/>      Don't know <input type="checkbox"/></p>									D	D	M	M	Y	Y	Y	Y									D	D	/	M	M	/	Y	Y	Y	Y	<p><b>J Role Description</b></p> <p><b>Main duties of the role (may be continued on a separate sheet if required)</b></p> <div style="border: 1px solid black; height: 300px; width: 100%;"></div>
D	D	M	M	Y	Y	Y	Y																												
D	D	/	M	M	/	Y	Y	Y	Y																										

<p><b>K Previous misconduct, disciplinary action or complaints</b></p> <p><i>Nature of allegation and what action was taken</i></p>	<p><i>Date</i></p>
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L	Previous / other employment (including any volunteer work if known)			
	Organisation / address	Job title / role	Date From	Date to





# Disclosure and Barring Service Referral Form

## Part 4: Reason for the referral

<b>M</b>	<p><b>Purpose of the referral</b></p> <p>I am referring the person because I think they <i>(please tick one only)</i>:</p> <p><input type="checkbox"/> Harmed a child or vulnerable adult through their actions or inactions <i>(relevant conduct)</i>; or</p> <p><input type="checkbox"/> Represent a risk of harm to a child or vulnerable adult <i>(satisfied the harm test)</i>; or</p> <p><input type="checkbox"/> Have received a caution or conviction for a relevant offence.</p>
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<b>N</b>	<p><b>Summary of the circumstances which has resulted in this person being removed from regulated activity</b> <i>(may be continued on a separate sheet if necessary)</i></p> <div style="border: 1px solid purple; height: 300px; margin: 10px 0;"></div> <p>Has the person you are referring admitted or accepted responsibility for any harm?                  Yes <input type="checkbox"/>      No <input type="checkbox"/>      Not Known <input type="checkbox"/></p>
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<b>O</b>	<b>Other organisations or agencies involved in the circumstances of the referral</b>			
	<i>Organisation / address</i>	<i>Contact person / role</i>	<i>Contact number</i>	<i>email</i>



# Disclosure and Barring Service Referral Form

## Part 5: Chronology of events

P	Chronology of events relating to this referral ( <i>please continue on a separate sheet if required</i> )			
	<i>Date</i>	<i>Event</i>	<i>Relevant documents</i>	<i>Persons involved</i>



# Disclosure and Barring Service Referral Form

## Part 6: Details of the child or vulnerable adult harmed / put at risk of harm

<p><b>Q</b> Details of the person harmed / put at risk of harm</p> <p>Title                  Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/></p> <p>Other title <input style="width: 100%;" type="text"/></p> <p>Surname  <input style="width: 100%;" type="text"/></p> <p>Forename(s)  <input style="width: 100%;" type="text"/></p> <p>Date of birth  <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/>  <small style="display: flex; justify-content: space-around; font-size: 8px;"> <span>D D</span> <span>M M</span> <span>Y Y Y Y</span> </small></p> <p>Or age if date of birth is not known <input style="width: 100px;" type="text"/></p> <p>Gender                  Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p><i>For additional victims please use a separate sheet</i></p>	<p><b>R</b> Relationship between the referred and the person harmed / put at risk of harm</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <p>Details of any vulnerability, e.g. emotional, behavioural, medical or physical</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>
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## Part 7: Documentation supplied

<p><b>S</b> Supplied documents (please tick all that apply)</p> <p>Application for employment <input type="checkbox"/></p> <p>Curriculum Vitae / CV / Resume <input type="checkbox"/></p> <p>References <input type="checkbox"/></p> <p>Letter of employment offer <input type="checkbox"/></p> <p>Job description / role requirement / person specification <input type="checkbox"/></p> <p>File notes concerning conduct, behaviour / attitude <input type="checkbox"/></p> <p>Care plans for those named in Section Q (where appropriate) <input type="checkbox"/></p> <p>Victim impact report(s) or statement(s) for those named in Section Q <input type="checkbox"/></p> <p>Documents of internal investigations and outcomes <input type="checkbox"/></p> <p>Documentation of any past disciplinary action and complaint(s) <input type="checkbox"/></p> <p>Statement(s) made by the referred individual <input type="checkbox"/></p>	<p>Investigations and reports of regulatory bodies <input type="checkbox"/></p> <p>Investigations and reports of other agencies or bodies <input type="checkbox"/></p> <p>Interview report(s) relating to the referral <input type="checkbox"/></p> <p>Witness statement(s) <input type="checkbox"/></p> <p>Dismissal / resignation / redeployment letters <input type="checkbox"/></p> <p>Local Authority investigations reports / documents <input type="checkbox"/></p> <p>Adult Social Care or Children's Services reports <input type="checkbox"/></p> <p>Police investigations and reports <input type="checkbox"/></p> <p>Minutes of Strategy Meetings <input type="checkbox"/></p> <p>Health and Social Care Trust Investigations reports / documents <input type="checkbox"/></p>
<p><b>T</b> Additional documents supplied (<i>please continue on a separate sheet if required</i>)</p>	



# Disclosure and Barring Service Referral Form

## Part 8: Referring party

<b>U</b>	<b>Referring organisation / establishment</b>	
	<b>Name of Organisation</b> <input style="width: 95%;" type="text"/>	<b>Contact address</b> <input style="width: 95%; height: 80px;" type="text"/>
	<b>Type of organisation</b> <input style="width: 95%;" type="text"/>	
	<b>Sector</b> Please select your sector of work	<b>Postcode</b> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
		<b>Country</b> <input style="width: 95%;" type="text"/>

<b>V</b>	<b>Primary contact</b>	<b>Alternative contact</b>
	<b>Name</b> <input style="width: 95%;" type="text"/>	<b>Name</b> <input style="width: 95%;" type="text"/>
	<b>Position</b> <input style="width: 95%;" type="text"/>	<b>Position</b> <input style="width: 95%;" type="text"/>
	<b>Telephone number</b> <input style="width: 95%;" type="text"/>	<b>Telephone number</b> <input style="width: 95%;" type="text"/>
	<b>Mobile number</b> <input style="width: 95%;" type="text"/>	<b>Mobile number</b> <input style="width: 95%;" type="text"/>
	<b>Email Address</b> <input style="width: 95%;" type="text"/>	<b>Email Address</b> <input style="width: 95%;" type="text"/>

## Part 9: Declaration

<b>W</b>	<b>To be signed by the person making the referral</b>  I confirm that to the best of my knowledge the information in this form is accurate and that I have provided all documents legally required and any other relevant documentation. I understand that the DBS may contact me about the information I hold on the person I have referred.  I understand that any information I have referred will be used by the Disclosure and Barring Service and may be disclosed to the referred person or other parties in accordance with statutory duties under the Safeguarding Vulnerable Groups Act 2006 and other legislation.
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# Disclosure and Barring Service Referral Form

<p><b>Signature</b></p> <input style="width: 100%; height: 20px;" type="text"/> <p><b>Name (in BLOCK CAPITALS)</b></p> <input style="width: 100%; height: 20px;" type="text"/> <p><b>Date</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="text-align: center; width: 10px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="text-align: center; width: 10px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">D</td> <td style="text-align: center; font-size: 8px;">D</td> <td></td> <td style="text-align: center; font-size: 8px;">M</td> <td style="text-align: center; font-size: 8px;">M</td> <td></td> <td style="text-align: center; font-size: 8px;">Y</td> <td style="text-align: center; font-size: 8px;">Y</td> <td style="text-align: center; font-size: 8px;">Y</td> <td style="text-align: center; font-size: 8px;">Y</td> </tr> </table>			/			/					D	D		M	M		Y	Y	Y	Y	<p><b>Position</b></p> <input style="width: 100%; height: 20px;" type="text"/> <p><b>Organisation</b></p> <input style="width: 100%; height: 20px;" type="text"/> <p><b>Relationship to the individual you are referring</b></p> <input style="width: 100%; height: 20px;" type="text"/>
		/			/																
D	D		M	M		Y	Y	Y	Y												

<p><input checked="" type="checkbox"/> <b>Returning the form</b></p> <p>Please check that you have answered all the questions you can and signed the Declaration.</p> <p>This form should be returned, together with all supporting documentary evidence, to the address opposite.</p>	<p><b>Please return the form to:</b></p> <p style="text-align: center;">Disclosure and Barring Service PO Box 181 Darlington DL1 9FA</p>
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<b>Reference No:</b> SG 37/13
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<b>Title:</b>	Adult Mental Health and Learning Disability Absent without Leave Procedure (AWOL)		
<b>Author(s)</b>	Mairead Mitchell, Senior Manager, Service Improvement and Governance Additional Authors: - Brendan Ingram, Noel McDonald, Jenni Armstrong, Barry Mills, Patricia Minnis, Agnes Dee, Kevin Mackel		
<b>Ownership:</b>	Catherine McNicholl, Director, Adult Social and Primary Care		
<b>Approval by:</b>	Standards and Guidelines Policy Committee Executive Team Meeting	<b>Approval date:</b>	3/7/13 19/8/13 21/8/13
<b>Operational Date:</b>	November 2013	<b>Next Review:</b>	November 2016
<b>Version No.</b>	V1.0	Supersedes	
<b>Key words</b>	AWOL, absent, absconding, leave, risk, MHLD		
<b>Links to other policies</b>	<ul style="list-style-type: none"> <li>Promoting Quality Care – Good Guidance on the Assessment and Management of Risk, DHSSPSNI, May 2010</li> <li>Belfast Health and Social Care Trust Patient Absent Without Permission Policy</li> <li>Belfast Health and Social Care Trust Safeguarding Adult Policy</li> </ul>		

<b>Date</b>	<b>V</b>	<b>Author</b>	<b>Comments</b>
Nov 07	0.1	T. McEneaney	Initial Draft. Sent out for comment
Feb 08	0.2		Comments received. Initial draft updated
08/09/08	0.2		Approved at Mental Health and Learning Disability Governance Group
08/09/08	0.2		Circulated to Adult Mental Health Inpatient Wards
09/10/12	0.3	B. Ingram, N. McDonald, J. Armstrong, B. Mills, A. Dee, K. Mackel, P. Minnis	Reviewed and updated. Sent out for Consultation – Mental Health and Learning Disability Services, Adult Social and Primary Care Directorate
20/02/13	0.4	P. Minnis	Updated after further consultation
07/03/13	0.4		Approved by Children's Disability and Learning Disability Governance Group subject to changes
09/04/13	0.4		Approved by Mental Health and CAMHS Governance Group

## **INTRODUCTION / PURPOSE OF POLICY**

### **1.1 Background**

Belfast Trust Mental Health and Learning Disability Services seeks to promote and maintain a caring and safe environment for all users admitted to any of the Trust's mental health or learning disability inpatient facilities.

However all staff must always be alert to the possibility that a patient may go missing either by absconding or leaving the inpatient facility.

Patients will be defined as absent without leave (AWOL) in accordance with the Mental Health Order (N.I) 1986 if they leave any of the Trust's mental health or learning disability inpatient facilities without permission/knowledge of staff or fail to return from escorted or unescorted leave.

### **1.2 Purpose**

To provide guidelines for staff to follow and implement when it is determined that a patient is absent without leave from any of the Belfast Trust's mental health or learning disability inpatient facilities and to assist in the safe return of the patient to the facility.

### **1.3 Objectives**

To provide staff with a standardised framework of best practice to implement when it is determined that a patient is absent without leave from any of the Belfast Trust's mental health or learning disability inpatient facilities.

To assist in the safe return of the patient to the inpatient facility.

To comply with all the recommendations from the following: -

- The Report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006.
- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007.

To be read in conjunction with: -

- The Mental Health (Northern Ireland) Order 1986
- Promoting Quality Care – Good Guidance on the Assessment and Management of Risk, DHSSPSNI, May 2010
- Belfast Health and Social Care Trust Patient Absent Without Permission Policy
- Belfast Health and Social Care Trust Safeguarding Vulnerable Adult Policy

## **2.0 SCOPE OF THE POLICY**

This policy applies to both voluntary and detained patients and all staff involved in the delivery of care to patients in mental health or learning disability inpatient facilities.

## **3.0 ROLES/RESPONSIBILITIES**

All staff working within the mental health or learning disability inpatient facility have a responsible role to play in achieving the above policy objectives.

There are specific roles and responsibilities outlined in the Policy for: -

- Escorting staff;
- Ward Sister/Charge Nurse/Nurse in Charge;
- Duty Nurse Manager/Senior Nurse Co-ordinator;
- Medical Staff/Duty Doctor;
- Multidisciplinary Team.

## **4.0 KEY POLICY PRINCIPLES**

The guidelines below set out the processes to be followed when a patient is discovered to be AWOL.

### **4.1 Levels of risk of patient absent without leave**

The level of risk of the missing patient should be determined by their care plan, risk assessment and multidisciplinary notes. All action taken must be recorded in the patient's notes, and other relevant documentation.

### **4.2 Staff escorting patient who goes absent without leave**

The member of staff will: -

- Remain within a safe distance of the patient where possible;
- Follow the recommendations stated within the patient's risk assessment;
- Contact the Nurse in Charge to advise of the incident;
- Return to the inpatient facility should they lose sight of the patient.

### **4.3 The Ward Sister/Charge Nurse/Nurse in Charge (hereafter referred to as the Nurse in Charge)**

The Nurse in Charge will: -



- Carry out an immediate search of the inpatient facility and surrounding areas;
- Having ascertained that the patient has left and not returned to the inpatient facility, contact the duty nurse manager/senior nurse co-ordinator;
- Attempt to contact patient – i.e. mobile phone, home phone, possible destinations?
- Complete Section 3 of the AWOL Form (Appendix 1);
- Inform the PSNI and provide personal and descriptive information including associated risks which are available on the AWOL form\*;
- Inform Medical Staff/Duty Doctor;
- Inform the next of kin/carer and provide advice about what to do if they locate the patient and a specific point of contact for communicating with staff throughout the period of absence;
- Contact relevant people listed in Section 4 of the AWOL form and complete this;
- Record in patient notes, risk assessment and care plan, giving the date and time the patient has gone absent without leave and record on any other daily returns documentation kept on the ward;
- Complete an incident form on DATIX within 24 hours;
- In the case of all Part III restricted patients going absent without leave contact the Department of Justice. A Health Social Care Board Serious Adverse Incident Report Form should also be completed and sent to the Operations Manager for processing.

**\* Should a patient be deemed a significant risk to either themselves or others, the PSNI should be contacted immediately.**

#### **4.4 Duty Nurse Manager/Senior Nurse Co-ordinator (in the event of a patient going AWOL from Windsor House or Mater Hospital, this role will fall to the Nurse in Charge)**

The Duty Nurse Manager/Senior Nurse Co-ordinator will: -

- Organise a search team for a search of the grounds;
- Contact the Senior Manager on Call if there is concern regarding the patient's vulnerability or risk status;

- Communicate with relevant personnel as per section four list;
- In the case of all Part III restrictive patients ensure the Department of Justice has been notified and that an HSC Serious Adverse Incident Report Form has been completed and forwarded to the Operations Manager

#### **4.5 Medical Staff/Duty Doctor**

The Medical Staff/Duty Doctor will liaise with the Nurse in Charge;

#### **4.6 Responsibilities for patients going absent without leave who are located outside of the Belfast Health and Social Care Trust catchment area**

The Belfast Health and Social Care Trust has ultimate responsibility for the safe return of the patient going absent without leave and this policy should be implemented for out of area AWOLs.

#### **4.7 General Hospitals**

If a patient who has been transferred to a general hospital goes absent without leave whilst in their care, it is the responsibility of that hospital to contact the Nurse in Charge of the mental health or learning disability inpatient facility and advise them of the appropriate details.

Staff from the mental health or learning disability inpatient facility involved in the transfer of the patient to the general hospital should advise the general hospital staff of this requirement on admission.

The Nurse in Charge of the mental health or learning disability inpatient facility will then initiate the absent without leave process and liaise with the general hospital to update them.

#### **4.8 Refusal to return**

If the patient is located and refuses to return, action taken will depend on the patient's legal status, risk and location.

If the patient is identified as absent without leave within a short period of time and known to be safe i.e. in the company of their carer/next of kin, the Nurse in Charge will discuss this with the Duty Doctor/Medical Staff to determine the appropriate response;

Attempts should be made to discuss the patient's return directly with the patient and/or carer/next of kin;

A joint decision may be made by medical and nursing staff to agree to overnight leave if they are satisfied that there is no immediate risk of

harm to the patient or others and that the patient will return subsequent to the agreed period of leave;

A full record of this decision detailing that an alternative plan of action has been agreed for the patient's return to hospital will be recorded in the patient's care plan, risk assessment and multidisciplinary notes;

The Nurse in Charge will ensure the patient and carer/next of kin has contact details for the inpatient facility should there be a change in circumstances and any advice appropriate to the patient's well being;

If it is deemed unsafe for staff to return the patient to the ward safely they should contact the PSNI for advice or assistance if required.

#### **4.9 Procedures to be followed on a patients return**

The Medical Staff/Duty Doctor will carry out a joint risk assessment in conjunction with the Nurse in Charge immediately regarding the patient's leave status and review level of observation;

The Medical Staff/Duty Doctor and Nurse in Charge will ascertain the reason for the patient going absent without leave and discuss the patient's leave status with them;

The Medical Staff/Duty Doctor must examine the patient on his/her return and recording findings in their care plan, risk assessment and multidisciplinary notes;

The patient may require to be searched as per policy;

The patient's notes will be updated to include levels of observation and leave status;

The Nurse in Charge will notify relevant people in Section 4 of the AWOL form and complete this;

The Nurse in Charge will update the incident form on DATIX.

#### **4.10 Multidisciplinary review following the patient's return following absent without leave incident**

The Multidisciplinary Team will review the absent without leave incident and update the patient's care plan, risk assessment and multidisciplinary notes.

## **5.0 IMPLEMENTATION OF POLICY**

### **5.1 Dissemination**

This policy will be disseminated to all staff within Mental Health and Learning Disability Services.

### **5.2 Resources**

No additional resources are required.

### **5.3 Exceptions**

The scope of this policy applies to the Mental Health and Learning Disability inpatient wards within Adult Social and Primary Care Directorate.

## **6.0 MONITORING**

An audit of the policy implementation will be carried out on an annual basis.

## **7.0 EVIDENCE BASE / REFERENCES**

- The Report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006.
- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007.
- Promoting Quality Care – Good Guidance on the Assessment and Management of Risk, DHSSPSNI, May 2010
- Belfast Health and Social Care Trust Patient Absent Without Permission Policy
- Belfast Health and Social Care Trust Safeguarding Vulnerable Adult Policy
- The Mental Health (Northern Ireland) Order 1986.
- The Human Rights Act 1998.
- The Northern Ireland Act 1998 (Section 75 Equality Considerations)
- Children (NI) Order 1995-The Regional Child Protection Policy and Procedures (ACPC 2005)
- The Data Protection Act 1998
- PSNI Golden Hour Initiative

## **8.0 CONSULTATION PROCESS**

This Policy has been developed following consultation with: -

Belfast Trust Mental Health and Learning Disability Services, Hospital and Community Services;  
Belfast Trusts Users, Advocacy and Carers Forums.

**9.0 APPENDICES / ATTACHMENTS**

Appendix 1 AWOL Form

**10.0 EQUALITY STATEMENT**

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

**Major impact**

**Minor impact**

**No impact.**

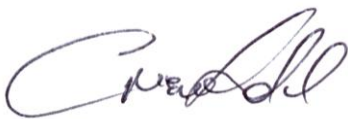
**SIGNATORIES**

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



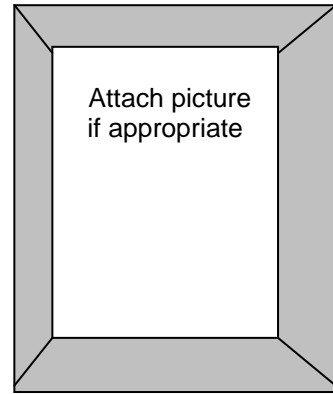
\_\_\_\_\_  
**Author**

**Date:** \_\_\_\_\_ **Nov 2013** \_\_\_\_\_



\_\_\_\_\_  
**Director**

**Date:** \_\_\_\_\_ **Nov 2013** \_\_\_\_\_



APP 1

**AWOL Form – To be completed by Nurse in Charge**

<b>Section 1:</b>				
<b>Name:</b>		<b>Gender:</b>		<b>Hospital No:</b>
<b>Consultant:</b>		<b>Signature of Nurse:</b>		<b>Date Completed:</b>
<b>D.O.B.</b>		<b>Age:</b>		<b>Nationality:</b>
<b>Time:</b>		<b>Ward:</b>		<b>Service:</b>
<b>Legal Status:</b>				
<b>Voluntary</b> <input type="checkbox"/>	<b>Pt II Detained</b> <input type="checkbox"/>	<b>Pt III Unres</b> <input type="checkbox"/>	<b>Pt III Res</b> <input type="checkbox"/>	<b>Other</b> <input type="checkbox"/>
<b>Bail Conditions:</b>				
<b>Admission Source/ Home Address:</b>				
<b>Height:</b>			<b>Complexion:</b>	
<b>Weight:</b>			<b>Eyes:</b>	
<b>Build:</b>			<b>Hair:</b>	
<b>Identifying Marks/Distinguishing Features i.e. tattoos, scars etc.</b>				
<b>Next Of Kin:</b>				
<b>Name of Admitting Nurse:</b>				<b>Signature:</b>

**Section II**

**Known Risks as documented in Risk Assessments**

**Harm to Self (including self harm/suicidal ideation, alcohol/substance misuse, neglect)**

**Harm from others (including vulnerable adult issues)**

**Harm to others (including child care and vulnerable adult issues, dissocial offending behaviour, violence and aggression)**

**Potential Victims**

**Other (should include any physical impairment or other risks)**

**Section III:**

**Date and time last seen/by whom/where:**

**Clothes Worn:**

**Jewellery:**

**Nurse Reporting:**

**Likely whereabouts or destination of missing patient:**

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_



**Section IV:**

**To be completed by the Nurse in Charge for a patient who goes missing**

**Date & Time Patient Returned to Ward:** \_\_\_\_\_

	Contacted when patient goes missing		Contacted when patient is returned to ward	
	Name	Time and by whom	Name	Time and by whom
Duty Nurse Manager/Senior Nurse Co-ordinator				
Medical Staff/Duty Doctor				
Next of Kin				
Emergency Duty Team				
Home Treatment Team				
Community Mental Health Team				
PSNI Station				
Emergency Departments				
PBNI				
PPU for Part III Patients				
Department of Justice for Part III Patients				
GP				

**Nurse in Charge:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Protecting our Older People in Northern Ireland

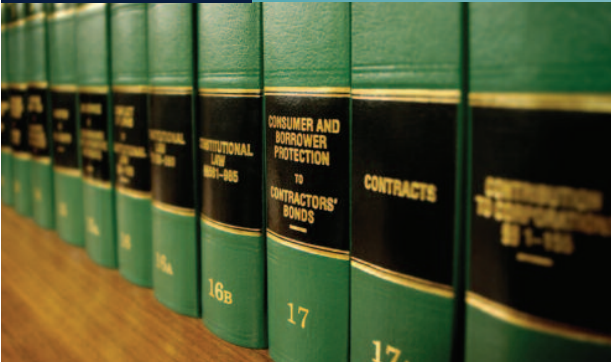
A Call for Adult Safeguarding Legislation

| June 2014 |



Legislation

Legislation is regarded as government, which are of to regulate, to proscribe, sanction, to authorize powers.



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# Commissioner's Foreword

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In my Corporate Plan, “Hope, Confidence, Certainty,” I committed to undertaking a review of the adequacy and effectiveness of law and policy in relation to older people so that they are better protected from a range of different types of abuse, including physical, emotional, sexual and financial abuse.

The Northern Ireland Adult Safeguarding Partnership (NIASP) has reported an increase in the number of cases of alleged abuse of older people, rising from 1715 in 2011-2012, to 3023 in 2013-14, marking a worrying trend.

This recent increase in the number of referrals and the feedback I received through extensive engagement with older people and older people's organisations, who expressed concern and anger about the increase in reports of alleged abuse, convinced me that there was a lack of legal protection available to older people who experience abuse.

As Commissioner for Older People, it is my responsibility to safeguard and promote the interests of older people, and so I commissioned a review of existing legislation in Northern Ireland in relation to protection for older people from abuse.

My review identified clear gaps in the legislation which mean that there are some areas in which older people are not adequately protected from abuse. At present, the legislation is disjointed, and draws on several different laws, and whilst it offers protection to individuals who have been deemed to lack mental capacity, those with mental capacity are not afforded the same protections from abuse. This is compared to England, Scotland and Wales, all of which have dedicated adult safeguarding legislation.

This report makes recommendations to Government which, taken together, culminate in a call for a single Adult Safeguarding Bill to be introduced to better protect older people in Northern Ireland. Older people in Northern Ireland must have confidence that they will be supported and protected. I am calling on the Minister of Health, Social Services and Public Safety and the Minister of Justice to introduce legislation which will give older people the certainty they need and deserve.

I would like to thank all the older people and the wide range of individuals and organisations from across the statutory, community, voluntary and independent sectors as well as the legal and academic professions who contributed to this report. All of these individuals and groups have been enthusiastic in giving their advice, support and direction, as well as the benefit of their experience throughout the development of this report which I hope will form the basis of future legislation that will ensure older people in Northern Ireland are better protected from abuse.

A handwritten signature in black ink, appearing to read 'Claire Keatinge'.

**Claire Keatinge**

# Editor's Note

by Professor John Williams, Head of Department, Law and Criminology at Aberystwyth University

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Elder abuse is a disturbing feature of modern life. Sadly, it has been with us as long as child abuse and domestic violence. However, there is now a growing awareness that it happens, in part because of the publicity given to high profile cases in institutional settings. We are slowly moving away from the stage of denial. It is disturbing to learn that in some places where older people are supposed to be safe, they are subjected to appalling abuse. Of course abuse is not confined to institutional settings. Older people are abused in their own homes. Such abuse takes many forms. It may be physical, sexual, psychological or wilful neglect. Financial abuse is a major area of concern. Sometimes the sum of money involved may appear small, but for a person living on a pension, the loss of that money may involve choosing between heating their homes and having a balanced diet. In other cases it may involve the older person being cheated out of their life savings or their home.

The question is asked – why do we need a special law designed to protect older people who have been abused or are at risk of abuse? Why can't the everyday laws be used to protect them? There are laws designed to protect *everybody* from harm. It may be the criminal law or there may be civil law that can be used. It is important that these are used in appropriate cases; older people are entitled to justice in the same way as everybody else. However, those agencies and organisations responsible for safeguarding and protecting older people need additional powers to ensure that they can intervene to investigate possible cases of elder abuse, and also provide immediate protection when necessary. It is essential that the law clarifies the roles, responsibilities and duties of those agencies and organizations, otherwise cases are missed. What is proposed in this report does not just apply to older people who are at risk; it also applies to all adults who may be at risk as result of disability or illness.

Any law proposing powers of intervention in the lives of older people at risk must be compliant with the European Convention on Human Rights. A number of rights are engaged as the justification for such a law. Articles 2 and 3 of the Convention guarantee the right to have life protected and the right to live free of inhuman and degrading treatment. These are absolute rights and the state has a positive duty to ensure that *all* people enjoy those rights. Article 5 provides for the right to liberty. Only in very limited circumstances and with essential safeguards, is it acceptable to deprive an older person of their liberty in their own home or in an institutional setting. The Article 8 right to private life, family life, home and correspondence is important as it protects the right to autonomy and the right of older people to live the way they want to live.

Any law on the protection of older people at risk must perform a careful balancing act between the protection of the person and respecting their right to autonomy. We do not want a law that is itself abusive and completely indifferent to the person's right to decide. Thus any law must be carefully drafted, include essential safeguards and at all times be proportionate in its scope and application. This is a big challenge for those charged with drafting and enacting legislation.

However, it can be done. The Adult Support and Protection (Scotland) Act 2007, with its significant powers of intervention, includes essential safeguards. The powers of intervention have not resulted in their widespread use; rather it has resulted in more preventative work. The ultimate aim of any legislation is not the extensive use of powers in response to allegations of abuse, but rather the need to change attitudes and challenge ageist assumptions.

The other European Convention right that needs to be emphasised is the Article 6 right to a fair hearing – the right of *all* people to receive justice. Many victims of elder abuse do not receive justice. More welfare support in response to abuse may be helpful and necessary, but it is not justice and it does not always ensure that the abuse stops. Older people deserve justice as well as being safe from further abuse. What they consider to be justice will of course vary given the dynamics of many cases of elder abuse. However, there needs to be a sense that the law is there to protect them.

The proposals made in this report address both the need for a law on protecting adults at risk and the need to ensure that such a law is not disproportionate and includes safeguards.

The case for a properly formulated law is compelling if we are to eradicate elder abuse. Practitioners working in this area need a statutory framework which identifies the parameters within which they can work. Older people at risk of, or are experiencing abuse need the protection of a carefully designed law that helps ensure that they live in a safe and supportive environment free of abuse.



**Professor John Williams**



*John Williams is a Professor of Law at Aberystwyth University. He is the author of many papers and books including "Protection of older people in Wales: a guide to the Law," published by the Older People's Commissioner for Wales.*

*In May 2012, he was appointed to the United Nations Panel of experts advising on international human rights and older people. He was the legislative advisor to the National Assembly of Wales on the Social Services and Well-being Act 2014 and is currently a member of the Welsh Government's Safeguarding Advisory Panel. He is a member of the working group advising the Welsh Government on a Declaration of Rights of Older People in Wales. John is a trustee of Age Ceredigion and Age Scotland.*

# Background

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## Safeguarding Older People - A Priority for Action in “Hope, Confidence, Certainty”

When the Commissioner for Older People for Northern Ireland undertook widespread engagement with older people in order to establish her priorities for action in her inaugural Corporate Plan, older people and older peoples’ groups raised concerns and anger about the abuse of older people.

When the Commissioner’s office looked at the statistics it became clear that there has been a rise in the number of reported incidences of alleged abuse against older people from individuals to Health and Social Care Trusts. This finding is compounded by statistics from the Northern Ireland Safeguarding Partnership (NIASP) which reported a marked increase in reports of alleged abuse of older people, increasing from 1715 in 2011-12 to 3023 in 2013-14<sup>1</sup> in Northern Ireland.

## What is Abuse?

The World Health Organisation (WHO) (2002) defines elder abuse as: *“a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights.”*<sup>2</sup>

Older people can be abused in many ways. The five most common forms of abuse as stated by Action on Elder Abuse are: physical, psychological, financial, sexual abuse and neglect.<sup>3</sup> In more recent years, reports of “institutional abuse” have been rising in the UK. This kind of abuse or harm takes place within a hospital or care home setting.

## Adult Safeguarding

Safeguarding adults is about working “to enable an adult to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect.”<sup>4</sup>

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1 Annual Adult Safeguarding Report 2013-14 – Health and Social Care Board

2 <http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html>

3 <http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html>

4 <http://www.elderabuse.org.uk/Documents/Other%20Orgs/ADASS%20guide%20-%20SAFEGUARDING%20ADULTS.pdf>

# Human Rights and Safeguarding Older People

## (by Professor John Williams)

Human rights are possessed by everyone and require the state to treat everyone appropriately, openly and fairly. They also require protection from other individuals who unjustly interfere with another person's rights.

Human rights are relevant to the abuse of older people in two ways:

1. Abuse of a human right may constitute abuse of an older person.
2. Human rights require the state to take necessary action to prevent abuse, wherever it happens and to respond to it appropriately.

The European Convention on Human Rights (ECHR) contains a number of rights that are relevant to the abuse of older people:

**Article 2:** "Everyone's right to life shall be protected by law."

**Article 3:** "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

**Article 5:** "Everyone has the right to liberty and security of person."

**Article 6:** "...everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law."

**Article 8:** "Everyone has the right to respect for his private and family life, his home and his correspondence."

**Article 9:** "Everyone has the right to freedom of thought, conscience and religion."

**Article 10:** "Everyone has the right to freedom of expression."

**Article 14:** "The enjoyment of the rights and freedoms shall be secured without discrimination on any ground..."

## Use of Case Studies

Anonymised case studies from the Commissioner's office are used in this report to add context where appropriate and to demonstrate how proposed recommendations could benefit older people at risk of abuse or harm.



# Executive Summary

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## The Commissioner's role and powers

1. When older people experience abuse or are at risk of abuse they must be confident that the law can adequately protect them.
2. The Commissioner has unique powers and duties that are set out in the Commissioner for Older People Act (Northern Ireland) 2011.<sup>5</sup> In her inaugural Corporate Plan, 'Hope, Confidence, Certainty,' the Commissioner set as one of her priorities "*to undertake a review of the adequacy and effectiveness of the law so that older people are better protected from abuse.*"
3. The Commissioner feels there is ambiguity regarding the law in relation to abuse that currently exists. This results in confusion for older people and for those caring for older people, including friends and family. The law needs to be clear, easy to understand, reflect equality and human rights legislation and must be proportionate regarding the right of autonomy and the right to be protected.
4. The Commissioner recognises that new legislation by itself will not protect older people from harm or abuse; however, the purpose of this report is to review legislation and guidance specifically and to make recommendations specific to this particular area.
5. It should be emphasised that the existence of a statutory power does not automatically mean that it has to be used. Powers underpinned by legislation need only be used in specific circumstances and any use of legislation should be proportionate and appropriate. It is essential and assumed that any new legislation is accompanied by adequate guidance, training and resources for effective implementation.
6. This report's focus is on the abuse and harm of older people and the interventions required to protect this group of people. It is acknowledged that the research undertaken and recommendations made will apply to adults of all ages, including older people.

## Context

7. Within the Northern Ireland Executive's 'Programme for Government 2011-15,' there is a commitment from the Northern Ireland Assembly to "*introduce a package of measures aimed at improving Safeguarding Outcomes for Children and Vulnerable Adults.*"<sup>6</sup> To deliver on this commitment the Executive will need to strike a balance between protection, prevention, human rights and the law.

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6 <http://www.northernireland.gov.uk/pfg-2011-2015-final-report.pdf>

8. The term 'vulnerable adult' covers a wide range of people; the bill being proposed by the Commissioner would apply to **all** adults, who are classed as being 'adults at risk' of harm or abuse. The Commissioner's statutory remit is confined to older people and focuses on reviewing the adequacy of the law in Northern Ireland relating to older people.
9. In Northern Ireland, older people are still not afforded 'adequate' legislative protection from potential abuse and consequently may not obtain justice. **All** older people should be protected from abuse or harm. New adult safeguarding legislation would assist in providing better protection. There is a disparity of protection within existing legislation for older people with mental capacity and those who are assessed as having "*a lack of mental capacity.*"<sup>7</sup>
10. A lack of mental capacity as defined by the Mental Capacity Act 2005 is as follows; "*a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.*"
11. For older people with mental illnesses, including dementia, there is a higher level of protection afforded through the Mental Health (Northern Ireland) Order 1986. In addition, the emerging draft Mental Capacity Bill for Northern Ireland will provide increased protection for older people who lack mental capacity.
12. Older people who have the mental capacity to make decisions but are under coercion from people with whom they have a relationship of trust or dependence can be particularly at risk of abuse. Currently there is no specific legal protection available for older people falling into this category and the recommendations made in this report focus particularly on addressing this gap and improving legislative protection to **all** older people 'at risk' of harm or abuse.
13. The Northern Ireland Adult Safeguarding Partnership (NIASP) has reported an increase in the number of referrals of alleged abuse of older people in Northern Ireland - rising from 1715 in 2011-12 to 3023 in 2013-14.<sup>8</sup> This shows a marked increase in alleged abuse against older people.
14. The impact that harm and abuse can have on older people is significant. An older person at risk of harm or abuse can experience intimidation, fear and social isolation alongside devastating physical and mental injuries if abuse or harm occurs.
15. The Commissioner sought research and advice from a consortium of academics and practitioners from Queen's University Belfast (QUB) and the University of Ulster (UU) and has engaged with professionals involved in adult safeguarding and organisations working with older people across Northern Ireland. The report submitted by the research team to the Commissioner identified a disjointed array of legislation currently in use in adult protection cases.

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<sup>7</sup> At the time of drafting the draft Mental Capacity Bill was at public consultation phase. The Bill includes both general safeguards to include best interests and additional safeguards for serious interventions.

<sup>8</sup> Annual Adult Safeguarding Report 2013-14 – Health and Social Care Board

16. Professionals involved in adult safeguarding and organisations working with older people are also calling for better and clearer protection for older people and legislation to provide clarity in a number of areas including statutory definitions, duties and powers.<sup>9</sup>
17. The Commissioner is concerned at the disjointed nature of the legislation to protect older people and by the lack of specific safeguarding legislation for older people at risk of harm or abuse in Northern Ireland.
18. Following on from the expert research and substantial engagement with representatives from across health, social care, the legal professions, the PSNI and older people's organisations, the Commissioner is now calling for better and clearer protection for older people in the form of a single Adult Safeguarding Bill for Northern Ireland.
19. The Commissioner recommends that this new Bill should provide clarity in terms of definitions, duties and powers for older people, their friends and families, as well as professionals who work with older people.
20. England, Scotland and Wales have legislation in place at this time, although each of the three have adopted a different approach to adult safeguarding. The Adult Support and Protection Act has been in place in Scotland since 2007. The Care Bill 2014 received Royal Assent on 14th May 2014 and is now an Act of Parliament in England<sup>10</sup> and the Social Services and Wellbeing Act 2014 has recently been enacted in Wales.<sup>11</sup>

## Summary of recommendations

21. The Commissioner for Older People is calling for the introduction of a single Adult Safeguarding Bill for Northern Ireland which will provide clarity in terms of definitions, duties and powers for all those working to safeguard older people. These proposed duties and powers would apply to all employees and organisations that are listed under the specified 'relevant organisations,' which should be outlined in future legislation.
22. The **definitions** used currently in adult safeguarding in Northern Ireland are unclear. A clear definition is required in terms of:

### 1. A "person who is at risk;"

Creating a single, clear and easy to understand definition of a person '**at risk of harm or abuse**' in statute is a critical first step. A clear definition will also help practitioners in their role by assisting them in the exercise of their professional judgement in complex circumstances. Robust and detailed guidance alongside a clear definition will also be required and should be underpinned by statute.

### 2. The "abuse or harm" – i.e; what they are at risk of;

A clear definition of '**harm or abuse**' as well as supporting guidance is also essential.

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<sup>9</sup> Practitioners also emphasised the need for the same vetting and training obligations for working with adults as are required for childcare.

<sup>10</sup> The Care Act 2014 received Royal Assent on 14th May 2014.

<sup>11</sup> The Social Services and Wellbeing Act 2014 received Royal Assent on 1st May 2014.

### 3. What constitutes “financial abuse;”

A clear and unambiguous definition of **‘financial abuse’** is also required. Reports of alleged financial abuse are rising in relation to older people. A specific legislative reference to financial abuse in new legislation will help support better recognition and identification of instances when financial abuse is occurring.

23. An **adult safeguarding board** empowered by statute should be created to act as an oversight body to protect older people at risk of harm or abuse. It would be a matter for this board to hold the relevant membership organisations to account. It is expected that “relevant organisations” would include all statutory, community and voluntary organisations working with older people.
24. Placing specific statutory **duties** on people who work with older people who are at risk of harm or abuse is required. These duties should apply to all relevant organisations working with older people, including the police, health and social care practitioners and care workers across all statutory, community and voluntary organisations.
  1. A **duty to report** any suspected cases of abuse or harm should be placed on all identified relevant organisations.
  2. A **duty** for the ‘most appropriate organisation **to make enquiries or conduct investigations** when a referral is received.’ The most appropriate organisation to make the enquiry or conduct the investigation should be determined on a case by case basis. There should also be a requirement to fulfill this designated duty in a timely fashion and to complete specific stages of enquiry or investigation, which should be outlined by accompanying guidance.
  3. All relevant organisations working with older people at risk of harm or abuse should also be bound by **a duty to provide appropriate services**. ‘Appropriate services’ here would include services such as advocacy.
  4. Throughout the safeguarding process, all relevant organisations should be bound by a legislative **duty to cooperate** with each other in order to best protect an older person at risk of harm or abuse.
25. Specific **powers** within new legislation to protect older people at risk are required. The Commissioner recognises that these would be used only with appropriate safeguards in place.
26. The **power of access** to a private home or residence **for the purposes of conducting a private interview** where access is not available should be implemented. ‘Reasonable cause’ here could be tested through an application to a District Judge and only if exercising the power would not result in the older person being at greater risk of harm or abuse. This power would allow for an independent assessment of a person’s situation. Further to this, safeguarding needs to take place in the absence of the suspected ‘abuser.’

27. The Commissioner recommends that there is **protection from civil liability for those people making a report of suspected abuse**. There should be additional support and encouragement for professionals who whistle blow so that they feel adequately protected when reporting allegations of suspected abuse.

### Issues for further consideration

28. The Commissioner requests consideration be given to a **power of removal** of the individual at risk and the **power to ban** a suspected 'abuser.' England and Wales have considered these powers and Scotland has implemented them within the *Adult Support and Protection Act 2007*. Further consideration of these powers for Northern Ireland at this time would gauge public and political opinion.
29. The Commissioner is requesting further consideration of the **power to access financial records** in Northern Ireland. This power is in place in Scotland but not in England and Wales. The Commissioner advises that an immediate campaign be undertaken to highlight the signs of financial abuse and the impact it has on older people across all financial institutions so that reporting and investigation of complaints of alleged financial abuse is actively encouraged.
30. The Commissioner requests further consideration on the introduction of a **specific criminal charge of elder abuse** where someone commits a crime against an older person by way of their action or neglect. It is thought that this may act as a deterrent to perpetrators of abuse or harm. There is currently no specific criminal charge of 'elder abuse' in England, Scotland and Wales but there is a campaign by Action on Elder Abuse to introduce this charge in England.<sup>12</sup>
31. The Commissioner requests further consideration of a **specific criminal charge of 'corporate neglect.'** The introduction of such a charge would mean that any organisation whose employees are found to have committed abuse or neglect of an older person could be liable for the actions of that employee.

### Conclusion

32. It is essential that older people are protected from abuse by the law. A single Adult Safeguarding Bill would introduce a statutory duty on all identified relevant organisations to work together to protect older people and help safeguarding practitioners to investigate the risk to individuals. Future legislation would ensure that Northern Ireland has a clear and defined legislative position on which to further develop good practice in the area of adult safeguarding.
33. Legislation by itself will not comprehensively protect older people from abuse. Detailed guidance, training and resources, as well as a public awareness campaign with the commitment of the public and relevant organisations to work together will ensure improved protection for older people from harm or abuse.
34. The Commissioner for Older People for Northern Ireland recommends that adult safeguarding legislation is enacted at the earliest possible opportunity and that public consultation on the additional areas for consideration, as outlined in this report, is undertaken.

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<sup>12</sup> [http://www.elderabuse.org.uk/Mainpages/Aboutus/aboutus\\_campaigns.html](http://www.elderabuse.org.uk/Mainpages/Aboutus/aboutus_campaigns.html)

# Commissioner's recommendations for an Adult Safeguarding Bill

## Definitions:

- A clear and easy to understand definition of an 'adult at risk.'
- An enhanced definition of 'abuse or harm.'
- A clear definition of financial abuse.

## Oversight:

- An adult safeguarding board on a statutory footing.

## Duties:

- A duty on identified relevant organisations to report suspected abuse or harm to the appropriate body.
- A duty on the most appropriate organisation to make enquiries or conduct investigations once a report or referral is made.
- A duty to provide appropriate services to an 'adult at risk.'
- A duty to cooperate with each other in safeguarding cases.

## Powers:

- A power of access to an individual believed to be at risk of harm or abuse for the purpose of conducting a private interview.

## Protection:

- Protection from civil liability for those making a report.

## Further consideration should be given to whether or not an Adult Safeguarding Bill should include:

- A power to remove an individual at risk.
- A power to ban a suspected 'abuser' from contacting the specified individual or attending a particular location.
- A power to access financial records.
- A specific criminal charge of 'elder abuse.'
- A specific criminal charge of 'corporate neglect.'

# 1.0 Context

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- 1.1 Protection for older people at risk of abuse is essential. The rate of reported incidences of alleged abuse against older people is increasing in Northern Ireland. The Northern Ireland Adult Safeguarding Partnership (NIASP) has reported a year on year increase in the number of referrals of alleged abuse of older people, rising from 1715 in 2011-12 to 3023 in 2013-14.<sup>13</sup> This shows a marked increase in alleged abuse against older people. For the previous year, 2013-14, 39% of all regional referrals were in relation to older people.<sup>14</sup> Harm and abuse can have a significant impact on older people. An older person at risk of harm or abuse can experience intimidation, fear and social isolation, alongside devastating physical and mental impacts if abuse or harm occurs.
- 1.2 Abuse can occur through someone's actions towards an individual or through the neglect of an individual. Abuse against older people often occurs within a relationship of trust or dependence. There are many forms of abuse; it can be physical, psychological, financial, sexual or through neglect.
- 1.3 The Commissioner has committed to examining existing adult protection legislation and its adequacy in relation to older people as a key priority for action in her Corporate Plan, 'Hope, Confidence, Certainty' 2013-2015.
- 1.4 The Commissioner for Older People (Northern Ireland) Act 2011 places a legislative duty on the Commissioner to "*encourage best practice in the treatment of older people*" and the power to "*make representations to relevant authorities about matters concerning the interests of older people.*"
- 1.5 Engagement with older people has highlighted a lack of knowledge about how the law protects them from abuse. There is also confusion about what happens if concerns about abuse are reported. This is reflected in the issues which are brought to the Commissioner's attention via her legal team.
- 1.6 In order to inform the basis for this report, a cross-functional team from Queen's University Belfast (QUB) and the University of Ulster (UU) completed a review of the existing adult safeguarding framework in Northern Ireland, the United Kingdom (UK), the Republic of Ireland, America and Australia.
- 1.7 The research report emphasises that Northern Ireland is the only part of the UK which does not have specific adult safeguarding legislation. The Adult Support and Protection Act 2007 is in place in Scotland and the Social Services and Well-being Act 2014 has recently been passed by the Welsh Assembly. The Care Act 2014 received Royal Assent on the 14th May 2014 and is now an Act of Parliament in England.

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<sup>13</sup> Annual Adult Safeguarding Report 2013-14 – Health and Social Care Board

<sup>14</sup> Ibid



- 1.8 The academic research, as well as a range of additional discussions with adult safeguarding professionals and organisations working with older people, has convinced the Commissioner of the need for urgent action to ensure that all older people at risk of harm or abuse are better protected.
- 1.9 Within the Northern Ireland Executive's 'Programme for Government 2011-15' there is a commitment from the Executive to "*introduce a package of measures aimed at improving Safeguarding Outcomes for Children and Vulnerable Adults.*"<sup>15</sup> How the Executive delivers on this commitment to safeguard vulnerable adults must strike a balance between protection, prevention, human rights - in particular dignity, autonomy and safety - and the law.
- 1.10 Whilst the Commissioner's statutory remit is confined to older people and focuses on reviewing the adequacy of the law in Northern Ireland relating to older people, this report and its recommendations should apply to adults of all ages in need of protection.

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<sup>15</sup> <http://www.northernireland.gov.uk/pfg-2011-2015-final-report.pdf>



## Current Position in Northern Ireland

- 1.11 The NIASP was established in 2010. It was put in place to “*determine the strategy for safeguarding vulnerable adults, develop and disseminate guidance and operational policies and procedures, monitor trends and outcomes, and evaluate the effectiveness of partnership arrangements.*”<sup>16</sup> It is not currently underpinned by statute. Within this partnership, there are Local Adult Safeguarding Partnerships (LASPs) in each Health and Social Care Trust area.
- 1.12 The Department for Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DOJ) are in the process of developing a new adult safeguarding policy. The Commissioner has been working in partnership with the departments to share the progress and direction of this report. It is anticipated that the Commissioner’s legislative recommendations will support the development of the new policy direction emerging from the departments.
- 1.13 There are currently various pieces of legislation in Northern Ireland that practitioners make use of to safeguard older people at risk of abuse or harm. These include:
- the Family Homes and Domestic Violence (Northern Ireland) Order 1998;
  - the Criminal Law Act (Northern Ireland) 1967;
  - the Terrorism Act 2000.

Whilst safeguarding professionals can make effective use of existing legislation, the legislative intent for two of these pieces of legislation was not to safeguard older people.

- 1.14 In Northern Ireland older people are still not afforded ‘adequate’ legislative protection from potential abuse and consequently may not obtain justice. **All** older people should be protected from abuse or harm. Improving legislation would assist in providing better protection. There is a disparity of protection within existing legislation for older people with mental capacity and those assessed as having a lack of mental capacity.
- 1.15 A lack of mental capacity is defined by the Mental Capacity Act 2005 is as follows; “*a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.*”
- 1.16 For older people with mental illnesses, including dementia, there is a higher level of protection afforded through the Mental Health NI Order 1986. In addition, the emerging draft Mental Capacity Bill will provide additional protection for older people who lack mental capacity.
- 1.17 Older people who have the mental capacity to make decisions but are under coercion from people with whom they have a relationship of trust or dependence can be particularly at risk of abuse. Currently there is no specific legal protection available for older people falling into this category and the recommendations made in this report focus particularly on addressing this gap and improving legislative protection to **all** older people at risk of harm or abuse.

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<sup>16</sup> <http://www.hscboard.hscni.net/publications/2012/20120905%20September%202012%20-%20NI%20Adult%20Safeguarding%20Partnership%20-%20Annual%20Report%202011-2012%20-%20PDF%20338KB.pdf>

# 2.0 Definitions

## Definitions:

- **A clear and easy to understand definition of an ‘adult at risk.’**
- **An enhanced definition of ‘abuse or harm.’**

## 2.1 A clear and easy to understand definition of an ‘adult at risk’

### Issue

- 2.1.1 Definitions of a ‘vulnerable adult’ vary in Northern Ireland. There is no agreed definition in specific legislation to safeguard adults. The main definition used is from the Safeguarding Vulnerable Adults: Regional Adult Protection and Policy Procedural Guidance 2006.<sup>17</sup> This describes a vulnerable adult as an individual who is *“in need of community care services or is resident in a continuing care facility...who may be unable to protect themselves from harm or exploitation.”* It is not clear what encompasses ‘community care services.’ This definition creates confusion and means that individual interpretations vary.
- 2.1.2 Legislation in England, Scotland and Wales contains updated definitions; the definition of a ‘vulnerable adult’ has been replaced by a definition of ‘an adult at risk.’
- 2.1.3 It is acknowledged that the emerging adult safeguarding policy from DHSSPS and DOJ will consider a new definition which defines a person *‘at risk of harm.’*

### Recommendation

- 2.1.4 New adult safeguarding legislation in Northern Ireland should consider the ‘adult at risk’ approach. The legislation should be clear and easy to understand. It should also state the specific criteria to be met and additional guidance should be provided to assist those using the definition.

### How this recommendation could better protect older people at risk

- 2.1.5 A clear and well constructed definition will help support better recognition of harm and abuse in safeguarding practice. It should also support a more consistent response by the various professionals involved in adult safeguarding cases and the quick and accurate identification of older people at risk of harm or abuse.

<sup>17</sup> ‘Safeguarding Vulnerable Adults: Regional Adult Protection & Policy Procedural Guidance,’ (HSCB, 2006), p.10.

## 2.2 An enhanced definition of ‘abuse or harm’

### Issue

- 2.2.1 There is no agreed definition of ‘abuse or harm’ in statute. The main definition of abuse used in Northern Ireland is the definition as stated in the Safeguarding Vulnerable Adults Policy and Procedural Guidance 2006.<sup>18</sup> This definition does not make the connection that a breach of human rights to an ‘adult at risk’ is ‘abuse.’
- 2.2.2 A definition of ‘abuse or harm’ with a focus on human rights would update the definition in line with good practice and legislation in place in other countries. England and Wales have adopted a definition of ‘abuse’ that includes human rights references in legislation for safeguarding adults.<sup>19</sup>
- 2.2.3 Scotland’s legislation differs from other parts of the UK as the definition of ‘harm’ is also included in recently amended adult safeguarding legislation. This is a wide ranging definition which includes self harm. It is not yet clear whether ‘self harm’ will be included in a revised definition of ‘abuse or harm’ for Northern Ireland and it is a matter which would merit further discussion and consideration in the advancement of any new legislation.
- 2.2.4 Article 8 of the European Convention on Human Rights (ECHR) gives the right *‘to respect for his private and family life, his home and his correspondence.’* Private life includes the right to decide for oneself, dignity and respect, the right to make what others may think are ‘unwise or eccentric decisions,’ and the right to refuse medical treatment. Under this Article, self harm could be argued to be an individual’s human right.
- 2.2.5 It is understood that the expected adult safeguarding policy from DHSSPS and the DoJ may include a definition of ‘abuse’ which follows the World Health Organisation’s (WHO) direction. The WHO (2002) defines elder abuse as: *“A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights.”*<sup>20</sup>

### Recommendation

- 2.2.6 The Commissioner recommends that the need for a clear definition should extend to clarity on the terms ‘abuse or harm’ and should reflect the definition used by the WHO. Alongside the enhanced definition, appropriate guidance will be required to clearly state the parameters of abuse or harm and the appropriate actions to be taken.

<sup>18</sup> <http://www.hscboard.hscni.net/publications/LegacyBoards/001%20Regional%20Adult%20Protection%20Policy%20and%20Procedural%20Guidance%202006%20-%20PDF%20249KB.pdf>

<sup>19</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/194272/No\\_secrets\\_\\_guidance\\_on\\_developing\\_and\\_implementing\\_multiagency\\_policies\\_and\\_procedures\\_to\\_protect\\_vulnerable\\_adults\\_from\\_abuse.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets__guidance_on_developing_and_implementing_multiagency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf)

<sup>20</sup> [http://www.who.int/ageing/projects/elder\\_abuse/en/](http://www.who.int/ageing/projects/elder_abuse/en/)

## How this recommendation could better protect older people at risk

- 2.2.7 An enhanced definition of ‘abuse or harm’ will help support better recognition of harm and abuse in safeguarding practice. It should also support a more consistent response by the various professionals involved in adult safeguarding cases and the quick and accurate identification of older people at risk of harm or abuse so that steps can be taken to better protect them.

## 2.3 A distinct and clear definition of financial abuse

### Issue

- 2.3.1 NIASP has reported financial abuse as the second highest recorded form of abuse in Northern Ireland, after physical abuse. Incidences of financial abuse in Northern Ireland are increasing, rising from 498 referrals of financial abuse relating to older people in 2012-13<sup>21</sup> to 598 in 2013-14.<sup>22</sup>
- 2.3.2 The definition of abuse used in Northern Ireland (the existing 2006 guidance) does include a sub-definition of financial abuse.<sup>23</sup> This definition is not, however, supported by existing legislation. New legislation should directly reference financial abuse.
- 2.3.3 General criminal law, including the Fraud Act 2006<sup>24</sup> provides protection for adults or older people when financial abuse is suspected to reach the threshold of a ‘criminal offence.’ Alleged cases of financial abuse are being reported more frequently and the occurrence of abuse against older people is rising.

### Recommendation

- 2.3.4 The Commissioner is recommending that a clear reference to financial abuse is included in any future adult safeguarding bill. Guidance alongside legislation should provide practical examples of financial abuse and enhance and strengthen the definition.

## How this recommendation could better protect older people at risk

- 2.3.5 A specific legislative reference to financial abuse in new legislation will help support better recognition and identification of instances when financial abuse is occurring. This will support those working with older people to take appropriate action. It would also assist identified relevant organisations to intervene and investigate complaints of financial abuse at an earlier stage.

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21 <http://www.hscboard.hscni.net/NIASP/Publications/Annual%20report%202012%20-%202013%20-%20PDF%20591KB.pdf>

22 Annual Adult Safeguarding Report 2013-14 – Health and Social Care Board

23 <http://www.hscboard.hscni.net/publications/LegacyBoards/001%20Regional%20Adult%20Protection%20Policy%20and%20Procedural%20Guidance%202006%20-%20PDF%20249KB.pdf>

24 <http://www.legislation.gov.uk/ukpga/2006/35/contents>



## 3.0 A Statutory Oversight Board

### Oversight:

- **An adult safeguarding board on a statutory footing.**

- 3.1 An **adult safeguarding board** empowered by statute should be created to act as an oversight body to protect older people at risk of harm or abuse. It would be a matter for this board to hold the relevant membership organisations to account. It is expected that 'relevant organisations' would include all statutory, community and voluntary organisations working with older people.
- 3.2 This board could have a similar framework to that of the Safeguarding Board for Children in Northern Ireland which was set up in 2011 under the *Safeguarding Board Act*.<sup>25</sup> An oversight board would help to ensure that the appropriate bodies are fulfilling their duties to safeguard adults at risk of abuse or harm.

<sup>25</sup> <http://www.legislation.gov.uk/nia/2011/7/contents>

# 4.0 Duties

## Duties:

- **A duty on relevant organisations to report suspected abuse or harm to the appropriate body.**
- **A duty on the most appropriate organisation to make enquiries or conduct investigations once a report or referral is made.**
- **A duty to provide appropriate services to an ‘adult at risk.’**
- **A duty to cooperate with each other in safeguarding cases.**

## 4.1 A duty on all relevant organisations to report suspected cases of abuse or harm to the appropriate body

### Issue

- 4.1.1 The legislation which exists in Northern Ireland does not include a duty on all employees and relevant organisations that work with older people to report suspected cases of abuse or harm.
- 4.1.2 The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 places a duty on registered health professionals to “*refer suspected cases of harm to the relevant body.*” Under this Order, other healthcare providers that are not contained in the list of ‘registered health professionals’ are not bound by a statutory duty to report.
- 4.1.3 The Safeguarding Vulnerable Adults Policy Guidance 2006<sup>26</sup> recommends that employees of community and voluntary organisations should report instances of abuse or harm. This is not currently underpinned by statute.
- 4.1.4 The Codes of Practice for Health and Social Care staff registered with the Northern Ireland Social Care Council (NISCC) advise of a duty to report suspected cases of abuse or harm to the Regulation and Quality Improvement Authority (RQIA).
- 4.1.5 The Criminal Law Act (NI) 1967 places a duty on citizens to report any ‘relevant offence.’ In practice, this is of limited use in the context of safeguarding older people at risk of abuse or harm as not all allegations of abuse would be classed as a ‘relevant offence’ to be dealt with by the police.

26 <http://www.hscboard.hscni.net/publications/LegacyBoards/001%20Regional%20Adult%20Protection%20Policy%20and%20Procedural%20Guidance%202006%20-%20PDF%20249KB.pdf>

- 4.1.6 The Public Interest Disclosure (NI) Order 1998<sup>27</sup> protects most workers who ‘whistle blow.’ In Northern Ireland the term ‘whistle blow’ is used to describe a situation where an employee makes a protected disclosure about wrongdoing in their workplace. The Public Disclosure Order sets out a list of examples of wrongdoing that qualify for an employee to disclose information. It covers allegations of criminal activity, health and safety compromises amongst other things.
- 4.1.7 The DHSSPS whistle blowing guidance states that *“if someone raises a genuine concern under whistle blowing arrangements, they will not be at risk of losing their job or suffering any form of retribution as a result and harassment or victimisation of a whistle blower will not be tolerated.”*<sup>28</sup> The Minister of Health, Social Services and Public Safety has recently further supported the need for whistleblowing stating *“not only is whistle blowing something that (they) could do but something that they should do.”*<sup>29</sup>
- 4.1.8 Adult Safeguarding Legislation in Scotland and Wales includes a duty on relevant organisations to report suspected cases of abuse. Wales has not imposed this duty on individuals. Key stakeholders in England have also campaigned for the inclusion of a duty to report within the Care Act 2014.
- 4.1.9 It is recognised that there is a question in terms of how far this duty would extend, from professionals working with older people to individual citizens, and this will require further detailed discussion. The Commissioner would be satisfied that, at a minimum, it should apply to anyone working with older people. It is assumed that anyone subject to this duty would be appropriately trained to recognise abuse and neglect and that an appropriate sanction should be in place for cases where the duty is breached.

## Recommendation

- 4.1.10 The Commissioner recommends that a statutory ‘duty to report’ all suspected incidences of abuse or harm to the appropriate body be placed on all those working with older people and that the list of “relevant organisations” should be identified by the legislation. There should also be guidance provided as to who the most appropriate body is for these individuals or organisations to make the report of abuse or harm to.

## How this recommendation could better protect older people at risk

- 4.1.11 A statutory duty to report suspected cases of abuse would compel everyone working with older people to make a report. This would extend the current duty on registered professionals and it could be expected that more potential cases of alleged abuse would be identified and referred.

27 <http://www.legislation.gov.uk/nisi/1998/1763/contents/made>

28 [http://www.dhsspsni.gov.uk/hss\\_\\_f\\_\\_07\\_-\\_2009\\_whistleblowing.pdf](http://www.dhsspsni.gov.uk/hss__f__07_-_2009_whistleblowing.pdf)

29 <http://www.theyworkforyou.com/ni/?id=2012-06-19.6.28>

4.1.12 Engagement with safeguarding practitioners and other professionals in relation to this recommendation raised the issue of resources. There must be supportive services in place to support employees who are upset or distressed due to reports of alleged abuse or making a report. The Public Interest Disclosure (NI) Order 1998 gives some protection to employees who report but it will be necessary for increased resources to implement appropriate supportive measures for all people working with older people at risk.

## 4.2 A duty on the most appropriate organisation to make enquiries or conduct investigations once a report or referral is made

### Issue

- 4.2.1 In Northern Ireland there is no specific statutory 'duty' to make enquiries or conduct investigations to safeguard adults at risk, other than when a suspected crime is reported to the Police Service of Northern Ireland (PSNI).
- 4.2.2 The Safeguarding Vulnerable Adults Policy and Procedural Guidance (2006)<sup>30</sup> outlines a duty for managers in Health and Social Care Services to investigate reports of abuse.
- 4.2.3 There is also guidance available on safeguarding vulnerable adults developed by 'Volunteer Now' for the DHSSPS.<sup>31</sup> This guidance is for "*voluntary, community and independent sector organisations.*" It provides direction on how organisations should make enquiries and conduct investigations when abuse is reported but it is not a statutory duty.
- 4.2.4 The PSNI has a duty to investigate reports of criminal conduct under the Police and Criminal Evidence NI Order (PACE) 1989. This does not apply to all adult safeguarding cases as not all abuse against older people at risk would be classed as criminal conduct.
- 4.2.5 Legislation in England and Scotland includes a duty on appropriate bodies to make enquiries or investigate cases of suspected abuse. In Scotland, an oversight body exists at local authority level to review serious cases and the work of each individual organisation to safeguard adults. It is expected that any future review of Scottish legislation will provide evidence of the positive impact of the oversight body in shaping best practice in adult safeguarding.

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30 <http://www.hscboard.hscni.net/publications/LegacyBoards/001%20Regional%20Adult%20Protection%20Policy%20and%20Procedural%20Guidance%202006%20-%20PDF%20249KB.pdf>

31 <http://www.volunteernow.co.uk/training-and-standards/safeguarding-vulnerable-adults-a-shared-responsibility>



## Recommendation

- 4.2.6 The Commissioner recommends that there should be a legislative duty to make enquiries or conduct an investigation placed on ‘relevant organisations.’ The most appropriate organisation(s) to make the enquiry or conduct the investigation should be determined on a case by case basis, in line with the guidance provided. The duty should be placed on a specified organisation(s) alongside the need to act quickly and effectively. There should also be a requirement to fulfill this designated duty to enquire or investigate and to complete specific stages of enquiry or investigation within a reasonable timeframe, which should be outlined by accompanying guidance.
- 4.2.7 As previously referenced, the Commissioner also recommends that an adult safeguarding board should be established to review serious cases and the work of individual organisations on safeguarding.

### How this recommendation could better protect older people at risk

- 4.2.8 A statutory duty to report is important to guarantee that action is taken once a referral of alleged ‘harm or abuse’ is made. An oversight board for adult safeguarding would ensure that everyone working with older people as clients are fulfilling their role to protect older people at risk and complying with statutory duties.

## 4.3 A duty to provide appropriate services to an adult at risk

### Issue

- 4.3.1 In Northern Ireland, the legislation on the provisions of services is outdated. The Health and Personal Social Services (HPSS) (Northern Ireland) Order 1972 includes a duty to “*make advice, guidance and assistance available and to make arrangements and provide the provision of suitable and adequate facilities.*”<sup>32</sup>
- 4.3.2 This legislation was augmented in 2003<sup>33</sup> with a section on quality, improvement and regulation. The aim of this legislation is to increase the quality of health and social care services provided and tackle issues of poor performance.
- 4.3.3 The NIASP states that their aim is to “*improve adult safeguarding provision and good practice over the next 5 years.*”<sup>34</sup>
- 4.3.4 The draft Mental Capacity Bill for Northern Ireland includes additional safeguards to “*protect older people who are assessed as lacking mental capacity.*” The draft bill requires authorisation and the use of an independent advocate in circumstances where the required intervention could have serious consequences for the individual.

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32 <http://www.legislation.gov.uk/nisi/1972/1265>

33 <http://www.legislation.gov.uk/nisi/2003/431/contents/made>

34 [http://www.hscbusiness.hscni.net/pdf/N\\_I\\_A\\_S\\_P\\_Strat\\_2013-18.pdf](http://www.hscbusiness.hscni.net/pdf/N_I_A_S_P_Strat_2013-18.pdf)

The role of an independent advocate in this case will be to consult with professionals to represent the individual at risk's view.

- 4.3.5 Advocacy is defined as “*speaking up or pleading the case for.*” There are different forms of advocacy; self-advocacy, peer advocacy and professional advocacy are some examples. Advocacy should enable older people to find and use their own voice wherever possible, as well speaking up on their behalf if needed.<sup>35</sup>
- 4.3.6 It should be emphasised that the provision of services will only be one part of the response from organisations and employees working with older people at risk of abuse or harm. A continuum of responses, from advice and information, advocacy, and finally, legal protection in serious and complex cases would be essential to better protect older people at risk.

## Recommendations

- 4.3.7 The Commissioner recommends that adult safeguarding legislation should clearly state the appropriate services that ‘relevant organisations’ are required to provide for an older person at risk of abuse or harm. These would include services such as advocacy and victim support.
- 4.3.8 The Commissioner is recommending that the safeguarding oversight board would have a role in ensuring all relevant organisations provide appropriate services to older people at risk of abuse or harm.

## How this recommendation could better protect older people at risk

- 4.3.9 Appropriate services, such as advocacy could help empower and support an older person at risk of abuse or harm. When an older person is at risk of abuse or harm they may have reduced independence and resilience which could make it difficult for them in a situation of abuse or harm. An independent advocate could advise the older person and provide assistance and options for their scenario.
- 4.3.10 A statutory duty to provide appropriate services to an adult at risk will support direct action being taken. Intervening at the stage where abuse is suspected is vital to empower and support the older person at risk.

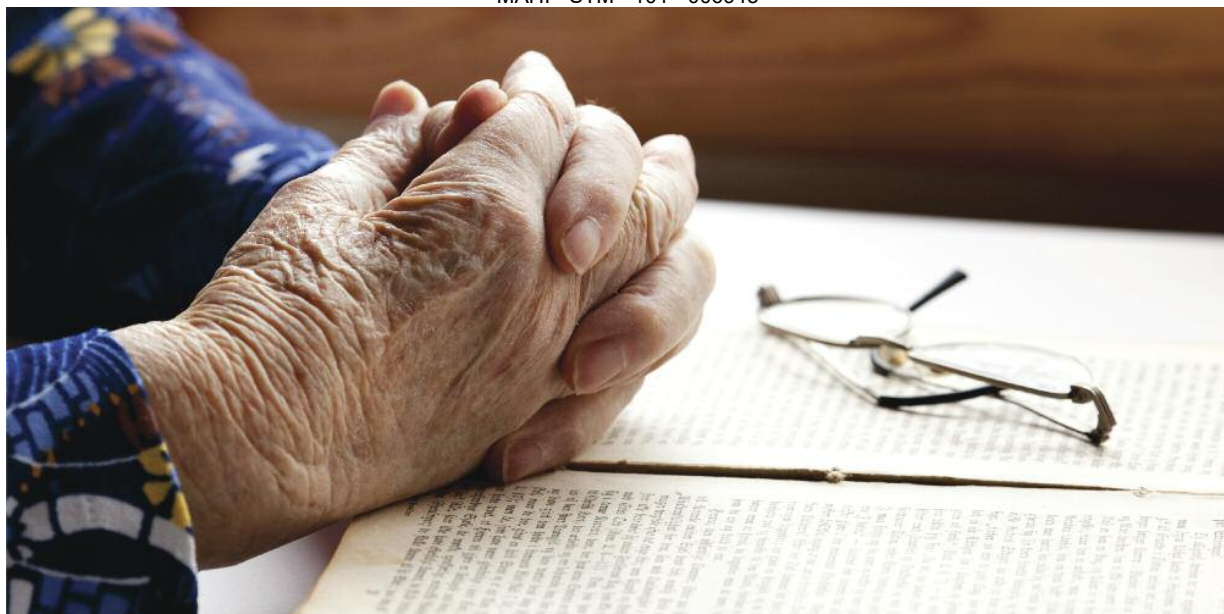
## 4.4 A duty on relevant organisations to cooperate with each other in safeguarding cases

### Issue

- 4.4.1 In Northern Ireland there is no statutory duty for people working with older people to cooperate in adult safeguarding cases.

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<sup>35</sup> Information Advice and Advocacy for Older People, 2005, Joseph Rowntree Foundation.



- 4.4.2 The Safeguarding Vulnerable Adults Policy and Procedural Guidance (2006) highlights the benefits of a multi agency approach in safeguarding. As this is not a statutory duty, the penalty for failing to follow the guidance is disciplinary action by the relevant organisation.
- 4.4.3 Engagement with safeguarding professionals by the Commissioner has identified that there can be a fear or reluctance amongst some professionals to share information in adult safeguarding cases. These professionals can be reluctant to share information due to data protection and confidentiality concerns. It will be necessary for work to be undertaken to prepare those working with older people for the better sharing of information across all relevant organisations.
- 4.4.4 Currently, adult safeguarding practitioners in Northern Ireland are relying on the good will of other professionals to share relevant information. Therefore a statutory obligation to cooperate rather than relying on good practice would help to provide increased sharing of relevant information and ultimately, better outcomes.

### **Recommendation**

- 4.4.5 The Commissioner recommends that a statutory duty be placed on all people working with older people to cooperate with each other on safeguarding cases. To enable organisations to fulfill this duty, there needs to be specific protocols in place for data protection and information sharing for investigatory purposes in adult safeguarding cases.
- 4.4.6 An adequate sanction should also be included alongside legislation for any 'relevant organisation' that fails to cooperate in a case relating to safeguarding older people at risk of harm or abuse.

### **How this recommendation could better protect older people at risk**

- 4.4.7 This duty would increase the effectiveness of multi-agency working in this area and provide improved protection for older people who are at risk of abuse or harm.

# 5.0 Powers

## Powers:

- A power of access to an individual believed to be at risk of harm or abuse for the purpose of conducting a private interview.

## 5.1 A power of access to an individual believed to be at risk of harm or abuse for the purposes of conducting a private interview

### Issue

- 5.1.1 There are situations that occur when an older person is suspected to be at risk of harm or abuse by an individual who can prevent safeguarding professionals from accessing the person at risk.
- 5.1.2 Currently in Northern Ireland there are a range of tools used by adult safeguarding practitioners on the ground to gain access to people or property. Professionals are skilled in maintaining open dialogue and using negotiation to gain access to individuals suspected to be at risk. There is a continued need for this important interaction between practitioners, suspected ‘abusers’ and the older person at risk to build effective relationships, but, on occasion, this will not be enough.
- 5.1.3 Article 129 of the Mental Health Order (NI) 1986 states that a Health and Social Care Trust or Board Officer may apply to a Justice of the Peace for a warrant to search a premises or remove an individual who is *“believed to be suffering from a mental disorder if they are or have been ill-treated or neglected or they are unable to care for themselves and they live alone.”*<sup>36</sup>
- 5.1.4 The QUB and UU research found that this is only normally used to gain access to an individual with a *“medically assessed mental disorder”* who needs assessment for hospital admission.
- 5.1.5 The PSNI have specific powers of entry for the purpose of *‘saving life or limb’* under the Police and Criminal Evidence NI Order 1989.<sup>37</sup> This may apply in some serious adult safeguarding cases but not when a practitioner requires access in order to have a conversation with the individual at risk and to assess the situation.

<sup>36</sup> <http://www.legislation.gov.uk/nisi/1986/595>

<sup>37</sup> Part III, Article 19 of the Police and Criminal Evidence (NI) Order 1989.

- 5.1.6 The Terrorism Act 2000 also includes a power of entry for police to *'preserve peace or maintain order.'*<sup>38</sup> Roundtable discussions with relevant organisations revealed that this Act has previously been used by police in safeguarding cases.
- 5.1.7 The power of access for a private interview would be an important power to fulfill the duty to make enquiries or conduct investigations.
- 5.1.8 Other parts of the UK are divided on the issue of including powers of access in legislation to safeguard adults. England has decided not to include a power of access in adult safeguarding legislation after consultation. A power of access is included in adult safeguarding legislation in Scotland and Wales.
- 5.1.9 A review of the use and effectiveness of the power of access in Scotland has not yet taken place. Discussions with safeguarding experts in Scotland have emphasised the usefulness of this power as a deterrent in practice.

## Recommendation

- 5.1.10 The Commissioner recommends a power of access for the purposes of conducting a private interview, with specific limitations in place. A power of access would allow a social worker and/or police officer to enter a home by means of a warrant. This would allow a social worker to speak privately to someone who they suspect could be at risk of abuse or harm, in order to ascertain that they are making decisions freely and to make an assessment of likely harm or abuse.
- 5.1.11 Baroness Greengross has campaigned for a *"power of access for confidential interview"* in England where:<sup>39</sup>
- There is reasonable cause to suspect a person is at risk of abuse or neglect;
  - Access is not available through any other means;
  - 'Reasonable cause' is tested via application to a Justice of the Peace; and
  - Exercising the power will not result in the person being at greater risk of abuse or neglect.
- 5.1.12 The Commissioner is recommending a power of access for private interview with similar limitations for an adult safeguarding bill in Northern Ireland.

## How this recommendation could better protect older people at risk

- 5.1.13 A power of access would enable a practitioner to carry out a private interview in order to make an assessment without the presence of the individual suspected of abusing the older person. This power is essential to protect older people under varying degrees of coercion, who are dependent on the individual and may feel unable to speak freely in their presence.

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<sup>38</sup> Part VII, Section 90. Terrorism Act 2000.

<sup>39</sup> <http://www.elderabuse.org.uk/Documents/Legislation/Power%20of%20Access%20briefing%20paper.pdf>

- 5.1.14 Proposing a power of access has clear human rights implications. It may be seen as an infringement of Article 8 of the ECHR - the right to private and family life - which identifies a person's home as important and something that should be respected. Human rights practitioners indicate that a power of access may be subject to challenge on this basis which is why the Commissioner is proposing that this is only in specific circumstances and subject to appropriate checks and balances.
- 5.1.15 The human rights of a person at risk in these circumstances could be further supported by the provision of access to a solicitor and special measures, such as those afforded for vulnerable witnesses,<sup>40</sup> when being interviewed.
- 5.1.16 An anonymised case study from the Commissioner's office is inserted below to demonstrate a situation where a power of access to carry out a private interview would have assisted practitioners and benefited the older person at risk of harm or abuse.

## Case Study 1

An older person's relative contacted the Commissioner's office and outlined a catalogue of safeguarding concerns. This older person, who had a learning disability, was residing at a care home, where they had married another resident. The older person's family had serious concerns about this marriage and contacted social services who were unable to stop the wedding. The older person was discharged from the care home by a relative of the new husband and the older person's family was prevented from contacting them. This older person's relative managed to locate them after prolonged investigations and discovered the older person in a serious state of neglect, after which the relative contacted the police and local Health Trust. The older person was deemed to have mental capacity at that time and remained in the care of the new husband's relative, despite the concerns of the family that this person was a malign influence on their relative. The family of the older person at risk were later contacted by a neighbour and advised that this older person was in hospital due to dehydration and malnourishment. The family obtained a court injunction preventing this older person's 'carer' contacting them.

How a power of access for private interview could have helped the older person in Case Study 1:

- When the older person's concerned family contacted social services, a power of access for private interview would have allowed practitioners to conduct a private interview to assess whether the older person was making decisions freely.
- In this case, a power of access for private interview would have revealed the level of abuse and neglect of the individual at an earlier stage.

- 5.1.17 A power of access for private interview is a strong protective measure for older people at risk where there is reasonable cause to suspect the person is at risk. If access is not available through any other means and exercising the power will not result in the person being at greater risk, it should be used by practitioners.

<sup>40</sup> <http://www.legislation.gov.uk/nisi/1999/2789/contents>



## 6.0 Protection

### Protection:

- Protection from civil liability for those making a report.

### 6.1 Protection from civil liability for those making a report

#### Issue

- 6.1.1 The Public Interest Disclosure (Northern Ireland) Order 1998<sup>41</sup> protects workers who ‘whistle blow,’ which provides a level of protection if the act is in good faith and procedures are followed. However organisations often have their own policies and procedures for whistle blowing practice. This results in varying levels of support available for staff who whistle blow.
- 6.1.2 Those professionals who attended the Commissioner’s roundtable consultation felt that additional support and protection may help to increase the number of reports made.
- 6.1.3 The issue is not just about the liability for making the report; it is also about liability for not correctly identifying abuse or neglect.

#### Recommendation

- 6.1.4 The Commissioner recommends that a high level of protection is afforded to all professionals and people working with older people who report suspected abuse or harm of older people. Consistent support and encouragement must be extended to all professionals who whistleblow so that they feel adequately protected in reporting allegations of suspected abuse.

#### How this recommendation could better protect older people at risk

- 6.1.5 People working with older people at risk of harm or abuse who are concerned about making a report will be more inclined to make the report if they are adequately protected.

<sup>41</sup> <http://www.legislation.gov.uk/nisi/1998/1763/contents/made>

# 7.0 Further Considerations

## Further consideration should be given to whether or not an Adult Safeguarding Bill should include:

- A power to remove an individual at risk.
- A power to ban a suspected 'abuser' from contacting the specified individual or attending a particular location.
- A power to access financial records.
- A specific criminal charge of 'elder abuse.'
- A specific criminal charge of 'corporate neglect.'

## 7.1 A power of removal

*A power of removal would involve the removal of an older person who is believed to be at risk of harm from the situation to a safe place for a period of time. If this power was considered for legislation it would be likely that an application for the power would be to a District Judge.*

### Issue

- 7.1.1 If there is a concern that a high level of abuse or harm will continue to happen after it has been identified, the power to remove the older person at risk of abuse or harm to a safe place for a specified period of time could help to better protect the individual at risk.
- 7.1.2 In consideration of a power of removal, there should be a discussion of how this would reinforce the power of access for a private interview. Powers implemented would be subject to safeguards and clearly defined guidelines which would ensure that the older person is not at greater risk of harm or abuse.
- 7.1.3 In a case where the individual suspected of causing the harm or abuse is also an 'adult at risk' but there are concerns about the older person's level of care, a power of removal may be a helpful intervention to protect the older person. An example of this can be seen in an anonymised case study from the Commissioner's office overleaf.



## Case Study 2

The Commissioner's office was contacted by a relative of an older person with concerns for their parent who was residing with another family member. The older person had been diagnosed with dementia. Their capacity for making legal and financial decisions was deemed to be 'fluctuating.' There were significant concerns about the level of care and supervision that this older person was receiving, including concerns that the older person was suffering from neglect. Attempts at providing regular 'respite care' proved difficult as the family member with caring responsibilities threatened on occasions to self-harm and the family were conscious of causing undue upset to the older person by removing them from familiar surroundings. The complexity of this case was enhanced by the fact that the older person was terminally ill. The relevant Health Trust subsequently implemented a safeguarding plan which provided day care with carer respite twice weekly. The older person was removed from his home and placed in emergency respite.

How a power of removal could have helped the older person in Case Study 2:

- The issue is the limited legal protection for older people at risk of abuse or harm who are assessed as having mental capacity, borderline capacity or uncertain or 'fluctuating' mental capacity.
- The Trust could not intervene early in this case as the older person was assessed as having 'fluctuating capacity.'
- Removal of the individual to a safe place for a period of time would allow the practitioner the opportunity to discuss the older person's wishes and would also allow time to put extra measures or procedures in place to further protect the older person at risk.
- A power to remove in this situation could have ensured that the older person was removed without undue delay, reducing the risk of further harm.

7.1.4 The Health and Personal Social Services (HPSS) (Northern Ireland) Order 1972, Article 37 permits:

*"the removal to suitable premises of persons in need of care and attention who are suffering from grave or chronic disease, or being aged, infirm or physically incapacitated, are living in insanitary conditions and are unable to devote themselves, or to receive from persons with whom they reside, or from persons living nearby, proper care and attention."*<sup>42</sup>

7.1.5 Discussions with the Northern Ireland Association of Social Workers (NIASW) indicated that this power has only been used twice and in both cases it was to protect an individual's life. It was also considered to be difficult to use because of the requirement to gain consent from the individual at risk, as specified in the Order. Practitioners are encouraged to apply to the High Court to determine the 'best interests' of the individual at risk, rather than use the HPSS Order 1972 in serious safeguarding cases.

<sup>42</sup> <http://www.legislation.gov.uk/nisi/1972/1265>

- 7.1.6 The Mental Health Order (Northern Ireland) 1986, Article 129 allows a Health and Social Care Trust or Board Officer to apply for a power of removal. Firstly, this order only grants power to the public sector, and so does not apply to community and voluntary sector organisations. Secondly, this power is only granted under the Order when the older person is assessed as lacking mental capacity. For an older person at risk, assessed as having mental capacity but who may be under coercion or without their personal resilience and independence, this safeguard is not available.

### Further consideration

- 7.1.7 The Commissioner is requesting further consideration of a power of removal in Northern Ireland, to be tested through public consultation.
- 7.1.8 The power of removal should only be considered in the most serious and significant cases given the fundamental Article 8 human right; the right to private and family life.

### How this consideration could better protect older people at risk

- 7.1.9 A power of removal would allow safeguarding practitioners to keep the older person who is at suspected risk of abuse or harm safe for a period of time. It also allows the practitioner time to talk to the individual about their situation without the suspected 'abuser' being present.
- 7.1.10 A potential risk associated with the power of removal is the impact that this power has on an individual's human rights. Both the right to liberty and security (Article 5) and the right to private and family life (Article 8) would be affected by this power. It could be argued that the state do not have any right to remove an older person at risk from their home as it is their decision to stay there, particularly for older people at risk who have mental capacity.
- 7.1.11 Scotland has included the power of removal as part of the protection orders within the Adult Support and Protection Act 2007.<sup>43</sup> There has been no review of the legislation in Scotland at this stage but discussions with Scottish practitioners have not reported any issues of concern with the power to remove in adult safeguarding.

## 7.2 A power to ban

*The power to ban is to prohibit a suspected 'abuser' of an individual from contacting that person or being in a specified place for a certain amount of time. This power could be granted by a District Judge.*

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<sup>43</sup> Section 14, Adult Support and Protection Act, 2007

## Issue

- 7.2.1 When harm or abuse against an older person has been identified, the power to ban the suspected 'abuser' from the person or a specific place for a period of time would mean that the older person at risk could be better protected.
- 7.2.2 There are pieces of legislation in Northern Ireland that include a power to ban an individual from a specific place or person for a period of time. These are not specific to safeguarding adults at risk of harm or abuse.
- 7.2.3 The Family Homes and Domestic Violence (Northern Ireland) Order 1998 can grant a power to ban a family member, partner or ex-partner from being in a specific place and from contacting a certain person.
- 7.2.4 The Harassment (Northern Ireland) Order 1997 provides the power for a civil injunction which gives a power to ban an individual from contacting the specified person with whom they have been involved in a course of harassing conduct.
- 7.2.5 The Anti-Social Behaviour (Northern Ireland) Order 2004 and the Northern Ireland Housing Order 2003 also include powers to ban.
- 7.2.6 Despite these powers already existing in legislation in Northern Ireland, they are for specific circumstances, such as domestic violence cases. These pieces of legislation may not be suitable for an older person who is at risk of abuse or harm and under coercion as the person affected needs to instigate the use of the power.
- 7.2.7 The power to ban a suspected 'abuser' to safeguard older people could, in certain circumstances, be enforced by the state.
- 7.2.8 In consideration of a power to ban, there should be consideration as to how the power to ban would reinforce the power of access for a private interview. Powers implemented would be subject to safeguards and clearly defined guidelines which would ensure that the older person is not at greater risk of harm or abuse.

## Further consideration

- 7.2.9 The Commissioner requests further consideration from Government and consultation on whether the power to ban should be included in future adult safeguarding legislation. An important consideration associated with this is the proposed role of the state in having this power.

## How this consideration could better protect older people at risk

- 7.2.10 There are specific circumstances of abuse or harm against an older person where the power to ban could help better protect older people. An example of such a situation can be seen in the anonymised case study from the Commissioner's office overleaf.

## Case Study 3

An older person had recently lost their partner of 35 years and had suffered a fall which resulted in a period of hospital treatment. During their stay in hospital the individual was visited by a person they had briefly met before. This person initially offered to provide assistance in preparing the older person's house for their return from hospital. Concerns were raised by neighbours when some items of the older person's property were sold by this person and there was a concern that money had gone missing from the older person's house. Neighbours were aware that the older person was vulnerable and contacted Social Services. Social Services are involved in the case but the older person is still susceptible to approaches from this particular person.

How a power to ban would have helped the older person in Case Study 3:

- When the neighbours reported concerns over this individual's motives with regard to the older person, investigations could have been made (which the duty to make enquiries and conduct investigations would cover.) Then when investigations revealed a level of abuse against the older person, powers of intervention would have been essential.
- The power to ban would have allowed practitioners to ban this individual from the older person, hospital and/or their house for a period of time.
- This time could have been used by practitioners to assess the older person's welfare and safety as well as their willingness to remain in the situation.

7.2.11 Scotland's Adult Support and Protection Act 2007 includes a power to ban.<sup>44</sup> It is too early to fully assess the effectiveness of the legislation but practitioners have voiced that having no criminal offence or sanction for breaching a banning order may impact the effectiveness of this power.<sup>45</sup> Therefore, from Scotland's example, any consideration of powers to ban in Northern Ireland should include an appropriate sanction.

7.2.12 The proposed power to ban received a mixed response from relevant organisations in Northern Ireland due to the impact on an individual's freedom of movement and their human right to liberty (Article 5, ECHR) which could make it difficult to implement.

7.2.13 The power to ban would need to be enforced by the state and as a result it would need to be established where the "burden of proof" lies. This means that it needs to be clarified whether the state would have to provide evidence that the individual is 'guilty' or whether the individual in question has to prove they are 'innocent'. This is why the power of the state to ban is a proposed step which the Commissioner feels would merit further, more detailed consideration.

<sup>44</sup> Part I, Section 19 Adult Support and Protection (Scotland) Act 2007.

<sup>45</sup> Comley, P. (2012) Adult Support & Protection: A report to Scottish Government around emerging issues and themes, Stirling: WithScotland

## 7.3 Power to access financial records

### Issue

- 7.3.1 In Northern Ireland, there are legislative powers in place to enable the appointment of an individual to look after someone else's financial affairs. There can be an issue when financial abuse occurs and there is a suspicion or allegation that the financial abuse is being carried out by the individual responsible for an older person at risk's financial affairs.
- 7.3.2 An Enduring Power of Attorney (EPA) allows someone to appoint one or more persons to act on their behalf, should they become incapable of making financial decisions in the future. This power becomes operational when the individual is assessed by a professional as lacking mental capacity.
- 7.3.3 The proposed draft Mental Capacity Bill will introduce a Lasting Power of Attorney (LPA) to replace the existing EPA scheme. This will allow a person to make decisions on someone else's behalf on **both** financial matters and health and welfare issues.
- 7.3.4 The Office of Care and Protection (OCP) has the responsibility for the management of the property and affairs of people in Northern Ireland, who through an assessed mental disorder are incapable of managing their own financial affairs. It is the OCP which have the power to grant EPA's.
- 7.3.5 Financial abuse needs to reach a certain threshold before the OCP will intervene. The OCP have implemented a maximum threshold of £20,000 which applies where Health Trusts are seeking an enduring Power of Attorney on behalf of patients. There is no minimum amount or limit for private applications. If the money involved exceeds £20,000 then the OCP have to gain a 'Controllership Order' to intervene.
- 7.3.6 When financial abuse occurs adult safeguarding practitioners have to report their concerns to the OCP; this is under their duty to report "*suspected financial abuse to an individual with a mental disorder*" under Article 107 of the Mental Health (Northern Ireland) Order 1986. With limited powers for practitioners to safeguard adults from financial abuse, there is a concern over the protection available. A delay in referring the suspected abuse to the OCP and then for the OCP to gain controllership could result in serious financial loss to the older person.
- 7.3.7 If adult safeguarding practitioners could access relevant financial records when there is reasonable suspicion of financial abuse, it would allow an assessment of the level of risk to the older person of whether financial abuse is occurring and any appropriate interventions required. Safeguarding practitioners have communicated to the Commissioner that financial institutions are keen to cooperate with them on suspicions of financial abuse but they are restricted in terms of their ability to share data or to intervene due to limited legal powers.

## Further consideration

7.3.8 The Commissioner recommends that further consideration of a power to access financial records in Northern Ireland should be considered and actively kept under review. In the intervening period, the Commissioner recommends that there is an immediate campaign undertaken to highlight the signs of financial abuse and its impact. This campaign should extend to engagement with financial institutions across Northern Ireland so that reporting and investigating complaints of alleged financial abuse is actively encouraged.

### How this consideration could better protect older people at risk

7.3.9 A power to access financial records, placed with a relevant, identified organisation could aid early identification of financial abuse and ensure that intervention is appropriate and quick. Ultimately, this could reduce large amounts of financial assets being lost for an older person at risk.

7.3.10 This power is included in legislation in Scotland. Communication with colleagues in Scotland revealed that access to financial records under the Adult Support and Protection Act 2007 is requested through a “section 10 application,”<sup>46</sup> and that this is served by the relevant statutory organisation on any party holding financial records. At present, the request system in Scotland seems to be working effectively alongside the duty to cooperate with investigations.

7.3.11 The issue of ‘autonomy’ over an adult’s own finances and the impact that this power would have on an individual’s human right to ‘respect for his private and family life’ remains an area of concern. An individual’s financial affairs are a matter for themselves. In the case of an older person at risk of financial abuse who has mental capacity, but perhaps does not ‘possess all the facts relating to the spending’ in order for them to make an informed decision, consideration of such a power has merit. In this case the individual might need assistance from the state to support them to gather a clear picture of all the facts.

## 7.4 A criminal charge of ‘elder abuse’

### Issue

7.4.1 In Northern Ireland there is no specific criminal charge of ‘elder abuse.’ However Article 121 of the Mental Health (Northern Ireland) Order 1986 provides an offence of ill-treatment or willful neglect of someone in a hospital or a nursing home being treated for a mental disorder.

7.4.2 Currently, no other part of the UK has a specific criminal charge of ‘elder abuse;’ Action on Elder Abuse have called for a criminal charge of ‘elder abuse’ to be introduced during consultation on the Care Bill 2013 in England.<sup>47</sup>

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<sup>46</sup> <http://www.legislation.gov.uk/asp/2007/10/contents>

<sup>47</sup> <http://www.elderabuse.org.uk/Documents/Legislation/AEA%202013%20Short%20Briefing%20Adult%20Safeguarding.pdf>



They proposed that this would cover circumstances “*where an adult uses their relationship or position to cause or allow an older person or dependent adult to suffer unnecessary physical pain or mental suffering, or injures their health, or steals, defrauds or embezzles their money or property.*”<sup>48</sup>

### Further consideration

- 7.4.3 The Commissioner requests that further consideration and consultation on whether a criminal charge of ‘elder abuse’ where someone commits a crime against an older person by way of action or through neglect should be undertaken. Associated with this would be the need to consider ‘vulnerability’ as an ‘aggravating factor’ in terms of sentencing.

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<sup>48</sup> <http://www.elderabuse.org.uk/Documents/Legislation/AEA%202013%20Short%20Briefing%20Adult%20Safeguarding.pdf>

## How this consideration could better protect older people at risk

- 7.4.4 A criminal charge of 'elder abuse' may act as a deterrent to perpetrators of abuse or harm and help to secure convictions and effective sanctions against people who abuse or harm the most vulnerable in our society.

## 7.5 A criminal charge of corporate neglect

### Issue

- 7.5.1 Another issue for consideration raised in the research and writing of this report is the proposal to develop a criminal charge of 'corporate neglect.'
- 7.5.2 At present in Northern Ireland there is no requirement for social care workers to be registered with NISCC. For some workers registration is not mandatory but optional at this point.
- 7.5.3 In a case of abuse against an older person whether the social care worker is registered or not, the responsibility should lie with the employer.
- 7.5.4 In England, there is ongoing consultation regarding a new offence of ill-treatment or willful neglect. As part of this consultation process there have been recommendations that a specific neglect offence is introduced to cover organisations such as corporate bodies and partnerships providing care services.

### Further consideration

- 7.5.5 The Commissioner requests that further consideration be given to the introduction of a criminal charge of corporate neglect for Northern Ireland. This is a matter that should be consulted on further both with the public and professionals.

## How this consideration could better protect older people at risk

- 7.5.6 A criminal charge of corporate neglect would encourage higher standards of care and better reporting of alleged abuse across all care services. Care providers could then be made liable for the actions of their staff and therefore would be encouraged to ensure the provision of high quality of care and better reporting.





## 8.0 Conclusion

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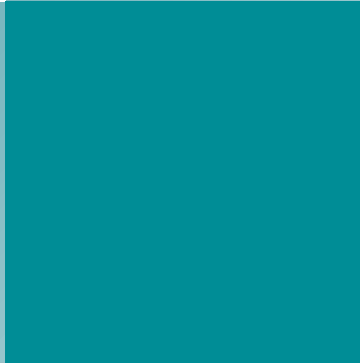
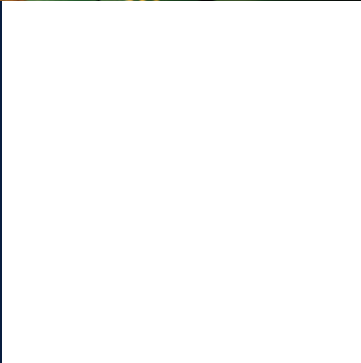
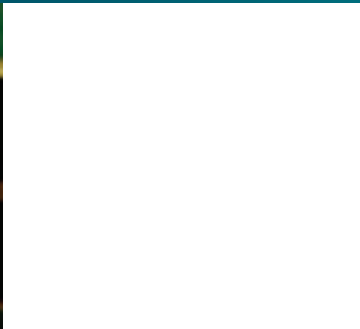
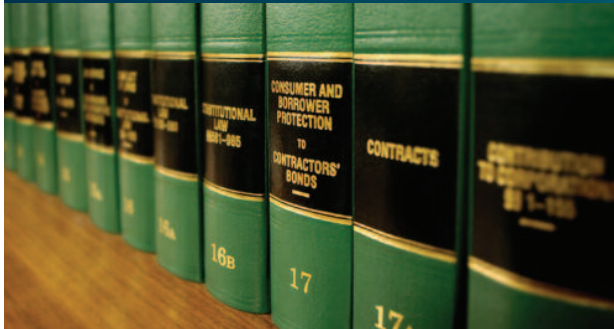
- 8.1 The Commissioner is calling for the creation of a single Adult Safeguarding Bill for Northern Ireland. The current legislation in Northern Ireland protecting older people at risk of harm or abuse is disparate and inadequate.
- 8.2 There needs to be a balance between protection of older people from abuse or harm, as well as prevention, and specific legislation underpinned by human rights principles. It is recognised that legislation on its own is not a solution but it is a crucial part of improving protection for older people at risk of harm or abuse.
- 8.3 This report highlights the key elements for consideration in any future adult safeguarding legislation. The Commissioner recommends that adult safeguarding legislation is enacted at the earliest possible opportunity and that public consultation on the additional areas for consideration, as outlined in this report, is undertaken.
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# Acknowledgements

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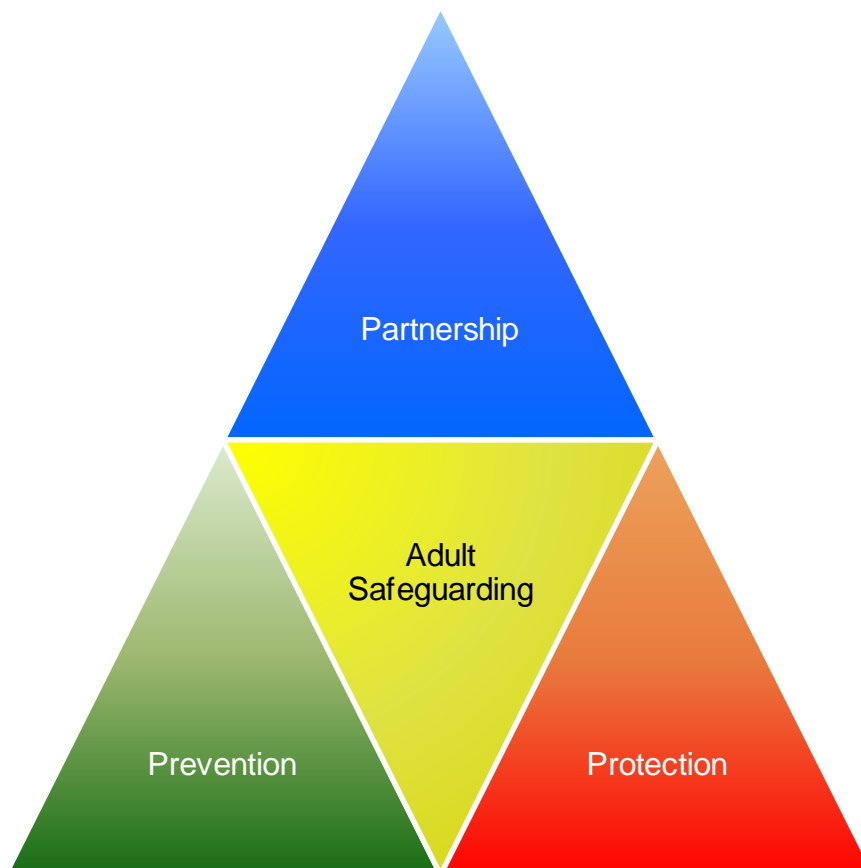
The Commissioner would like to thank the individuals and organisations who took the time to contribute to this report, in particular:

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- All other participants at the Commissioner's roundtable discussion



# Adult Safeguarding

## Prevention and Protection in Partnership



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This policy document replaces Part 1 of ‘Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance’ September 2006.

## **Foreword by the Minister for Health, Social Services and Public Safety**

As each of us goes through life we encounter many challenges. For the most part we are able to overcome them, equipped with our experiences, knowledge and with support from friends or family.

The challenges of dealing with abuse, exploitation or neglect should never arise, but they can and they do. The harm caused can have a devastating and long-lasting impact on victims, their families and carers.

Unfortunately, some adults are more at risk of harm than others. Safeguarding adults at risk is a priority for the Northern Ireland Executive and a Programme for Government commitment.

As far as possible, the aim of the policy is to prevent harm from occurring in the first place, to offer effective protection to those who are harmed and to provide them access to justice.

This policy makes it clear that we must not tolerate harm to adults caused by abuse, exploitation or neglect. It promotes partnership working for the purpose of safeguarding and seeks to keep adults safe wherever they live and whenever they access services.

It is acknowledged that safeguarding adults is complex and challenging and requires the careful exercise of professional judgement.

I want to acknowledge the very positive contribution to safeguarding delivered by a wide range of organisations across the statutory, voluntary, community, independent and faith sectors. I believe this adult safeguarding policy sets the way forward for all of us to work together to improve adult safeguarding practice.

I am confident that the implementation of this policy will prevent and reduce the risk of harm and improve safeguarding outcomes and I commend it to you.



**Simon Hamilton MLA**  
**Minister for Health, Social Services and Public Safety**

## Foreword by the Minister of Justice

As Ministers we are committed to ensuring that steps are taken to identify those who may be at risk of harm and, working together with others, improve the safeguards that are in place to protect them. Along with other institutions and bodies, we can provide increased protections and ensure that where a crime has been committed support services and access to justice are available. There are many areas in which adult safeguarding issues are of interest to the criminal justice sector, including a range of crime types such as domestic and sexual violence, hate crime and human trafficking among others. The publication of this adult safeguarding policy improves the safeguards that are in place and, in conjunction with a range of changes to the criminal justice system in recent years, means that more support is available for those who are unfortunate enough to become a victim of crime.

Recent improvements to the criminal justice system mean that those that are at risk of harm and the victim of crime are provided with additional support and entitlements. A victim and witness care unit has been established, providing victims of crime with a single point of contact for as much of the criminal justice system as possible. Registered intermediaries schemes are enabling those with significant communication difficulties to give evidence to the police and at court. In addition, a range of special measures continue to be available to enable vulnerable and intimidated victims and witnesses give their best evidence to both the police and at court. A Victim Charter has also been published, setting out the services to be provided to, and entitlements of, victims of crime as they move through the criminal justice process. This will be placed on a statutory footing later this year.

While it will never be possible to remove the potential for harm to occur, what we can do is ensure that there is effective support and protection for those individuals who have been subject to harm as they move through the criminal justice process. We can also provide increased access to justice for victims and their families when harm does occur and a crime has been committed. We want to place a greater focus on early intervention, protection and enabling those who suffer harm to have a greater voice within the justice process. The publication of the new adult safeguarding policy is a key development in this area.



**David Ford MLA**  
**Minister of Justice**

## 1. INTRODUCTION

Everyone has a fundamental right to be safe. Whatever the cause, and wherever it occurs, harm caused to adults by abuse, exploitation or neglect is not acceptable. This policy emphasises that safeguarding is everyone's business and that as good citizens we should all strive to prevent harm to adults from abuse, exploitation or neglect.

The aim of this policy is to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect. It has been jointly developed and published by the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DOJ) on behalf of the Northern Ireland Executive. It sets out how the Northern Ireland Executive intends adult safeguarding to be taken forward across all Government Departments, their agencies and in partnership with voluntary, community, independent and faith organisations. A key objective is to reduce the incidence of harm from abuse, exploitation or neglect of adults who are at risk in Northern Ireland; to provide them with effective support and, where necessary, protective responses and access to justice for victims and their families. The policy contributes to fulfilment of a Northern Ireland Executive Programme for Government commitment to deliver a package of measures to safeguard children and adults who may be at risk of harm and to promote a culture where safeguarding is everyone's business.

The policy requires a cross-departmental approach within government because the delivery of improved safeguarding outcomes is the business of us all, as individuals, as members of communities, as providers of services, and as Government Departments responsible for the delivery of strategies and policies which directly or indirectly impact on the lives of all adults including those at risk. The policy requires us to put all individuals who may be at risk at the centre, to listen to and respect their views, and to work in partnership with them and on an inter-agency basis to create a society which has a zero-tolerance of harm to the most vulnerable adults living in Northern Ireland.

Within this policy the term 'safeguarding' is used in its widest sense, that is, to encompass both activity which **prevents** harm from occurring in the first place and activity which **protects** adults at risk where harm has occurred or is likely to occur without intervention.

By introducing this policy we aim to raise awareness of harm to adults at risk, define what harm is, how it manifests itself and importantly how we respond to it. The act of protecting against harm is principally the responsibility of Health and Social Care Trusts (HSC Trusts), and the Police Service of Northern Ireland (PSNI) where a crime is alleged or suspected. However the responsibility of preventing harm is shared more widely. It extends beyond statutory providers of services to the voluntary and community sector, financial institutions, the legal profession, faith-based organisations, independent health and social care providers, carers and all citizens.



## 2. WHAT DO WE MEAN BY SAFEGUARDING

The majority of adults live full, independent lives free from harm caused by abuse, exploitation or neglect. However, there is a growing recognition that some adults, for a wide variety of reasons, may have been harmed or may be at risk of harm. The full extent of the incidents of harm caused to adults in Northern Ireland is not known but it is suspected to be significantly under-reported.

The language of adult safeguarding previously focused on protection and used the term 'vulnerable adult.' This was widely misinterpreted, often used out of context and, for some, the term implied weakness on the part of the adult, which many found unacceptable. This policy moves away from the concept of 'vulnerability' and towards establishing the concept of 'risk of harm' in adulthood. It places the responsibility for harm caused with those who perpetrate it. Harm resulting from abuse, exploitation or neglect violates the basic human rights of a person to be treated with respect and dignity, to have control over their life and property, and to live a life free from fear. Harm can have a devastating and long lasting impact on victims, their families and carers. It is the impact of an act, or omission of actions, on the individual that determines whether harm has occurred. Any action which causes harm may constitute a criminal offence and/or professional misconduct on the part of an employee.

Adult safeguarding is based on fundamental human rights and on respecting the rights of adults as individuals, treating all adults with dignity and respecting their right to choose. It involves empowering and enabling all adults, including those at risk of harm, to manage their own health and well-being and to keep themselves safe. It extends to intervening to protect where harm has occurred or is likely to occur and promoting access to justice. All adults at risk should be central to any actions and decisions affecting their lives.

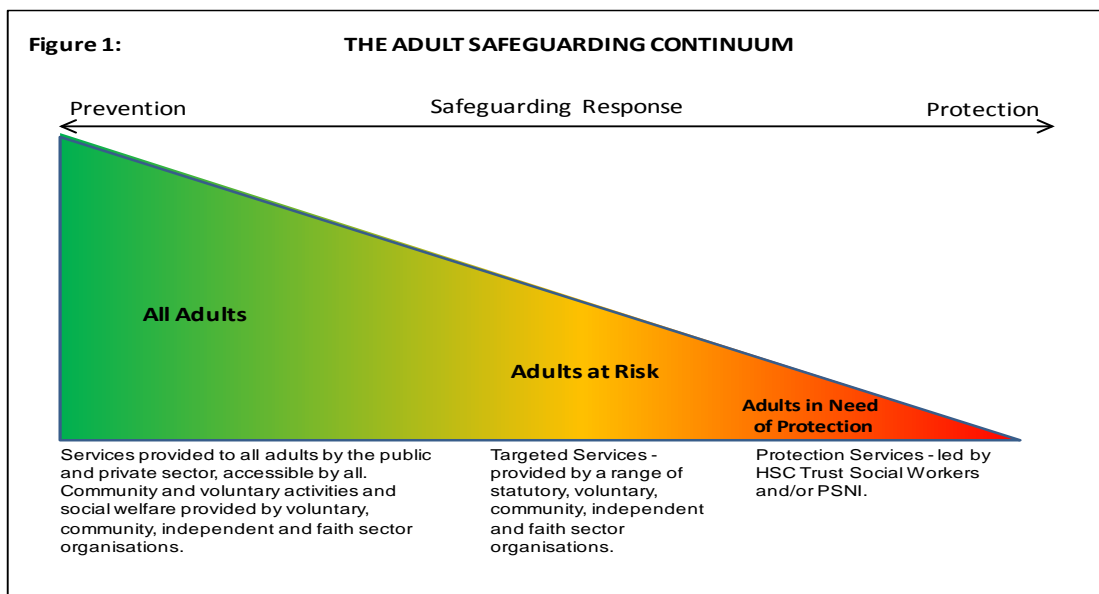
Safeguarding adults is complex and challenging. The focus of any intervention must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the adult's choices and preferred outcome for their own life circumstances. The right of a person with capacity to make decisions and remain in control of their life must be respected. Consideration of 'capacity' and 'consent' are central to adult safeguarding, for example, in determining the ability of an adult to make lifestyle choices, such as choosing to remain in a situation where they risk being harmed or where they choose to take risks. There should always be a presumption of capacity to make decisions unless there is evidence to suggest otherwise and current guidance for professionals in respect of determining capacity should be followed (see section 12). However there are also some circumstances when it may be necessary to consider the protection and rights of others, and overriding the withholding of consent may be necessary to ensure the protection of others.

**Preventative Safeguarding** includes a range of actions and measures such as practical help, care, support and interventions designed to promote the safety, well-being and rights of adults which reduce the likelihood of, or opportunities for, harm to occur. Effective preventative safeguarding requires partnership working, that is, individuals, professionals and agencies working together to recognise the potential for, and to prevent, harm. Prevention is therefore the responsibility of a wide range of

agencies, organisations and groups; indeed it is the responsibility and concern of us all as good citizens and neighbours. All professionals and service providers across the public, private, statutory, voluntary, community, independent, and faith sectors that come into contact with adults, including those who may be at risk of harm, must be alert to the individual's needs and any risks of harm to which they may be exposed. Prevention will strive towards early intervention to provide additional supports at all levels for adults whose personal characteristics or life circumstances may increase their exposure to harm.

**Protective Safeguarding** will be targeted at adults who are in need of protection, that is, when harm from abuse, exploitation or neglect is suspected, has occurred, or is likely to occur. The protection service is led by HSC Trusts and the PSNI. The input of other individuals, disciplines or agencies may be required, either in the course of an investigation of an allegation of harm or in the formulation and delivery of a care and protection plan.

Figure 1 shows the continuum of adult safeguarding activity from prevention to protection.



### 3. THE AIMS OF THIS POLICY

This policy aims to:

- promote zero-tolerance of harm to all adults from abuse, exploitation or neglect;
- influence the way society thinks about harm to adults resulting from abuse, exploitation or neglect by embedding a culture which recognises every adult's right to respect and dignity, honesty, humanity and compassion in every aspect of their life;
- prevent and reduce the risk of harm to adults, while supporting people's right to maintain control over their lives and make informed choices free from coercion;
- encourage organisations to work collaboratively across sectors and on an inter-agency and multi-disciplinary basis, to introduce a range of preventative measures to promote an individual's capacity to keep themselves safe and to prevent harm occurring;
- establish clear guidance for **reporting** concerns that an adult is, or may be, at risk of being harmed or in need of protection and how these will be **responded** to;
- promote access to justice for adults at risk who have been harmed as a result of abuse, exploitation or neglect;
- promote a continuous learning approach to adult safeguarding.

#### 3.1. WHO IS THIS POLICY FOR?

The policy is intended to assist organisations, their staff and volunteers who are in contact with or providing services to adults across the statutory, voluntary, community, independent and faith sectors. While it is intended to be applied by managers, employees and volunteers in the course of the delivery of services and organisational activity, it can also be applied by individuals acting as responsible citizens at home and in local communities.

There is an expectation that all organisations and their staff will work in partnership as they apply this policy to their work with adults who may be at risk of harm or in need of protection. Appendix 1 lists some examples of organisations for whom this policy may have specific relevance, however this is not intended to be an exhaustive list.

#### 4. UNDERPINNING PRINCIPLES

All Adult Safeguarding activity must be guided by five underpinning principles:

**A Rights-Based Approach:** To promote and respect an adult's right to be safe and secure; to freedom from harm and coercion; to equality of treatment; to the protection of the law; to privacy; to confidentiality; and freedom from discrimination.

Agencies and professionals who intervene in the lives of adults at risk should be guided by current best practice, the law and respect for rights set out in the European Convention on Human Rights<sup>1</sup> and enshrined in domestic law by the Human Rights Act 1998<sup>2</sup>, acting in accordance with relevant UN and EU Conventions<sup>3</sup> on the Rights of Persons with Disabilities and the UN Principles for Older Person's 1991<sup>4</sup>. Any intervention to safeguard an adult at risk should be human rights compliant. It should be reasonable, justified, proportionate to the perceived level of risk and perceived impact of harm, carried out appropriately, and be the least restrictive of the individual's rights and freedoms. It cannot be arbitrary or unfair, and all adults should be offered the same services on an equal basis.

**An Empowering Approach:** To empower adults to make informed choices about their lives, to maximise their opportunities to participate in wider society, to keep themselves safe and free from harm and enabled to manage their own decisions in respect of exposure to risk.

For adults at risk of harm, empowerment is a process through which individuals are: enabled to recognise, avoid and stop harm; facilitated to make decisions based on informed choices including provision of support for those who lack capacity to make decisions; assisted to balance taking risks with quality of life decisions; supported and enabled to seek redress; and for adults who have been harmed, a process whereby they are enabled to recover their self-confidence and self-determination and make informed choices about how they wish to live their lives.

**A Person-Centred Approach:** To promote and facilitate full participation of adults in all decisions affecting their lives taking full account of their views, wishes and feelings and, where appropriate, the views of others who have an interest in his or her safety and well-being.

A person-centred approach is a way of working with an individual to identify how he or she wishes to live their life and what support they require. A person-centred approach to adult safeguarding demonstrates respect for the rights of the individual

<sup>1</sup> *The European Convention on Human Rights* can be accessed at:

[http://www.echr.coe.int/Documents/Convention\\_ENG.pdf](http://www.echr.coe.int/Documents/Convention_ENG.pdf)

<sup>2</sup> *The Human Rights Act 1998* can be accessed at:

<http://www.legislation.gov.uk/ukpga/1998/42/contents>

<sup>3</sup> Relevant Conventions include *The UN Convention on the Rights of Persons with Disabilities*, the *UN Convention on the Elimination of Discrimination Against Women (CEDAW)*, and the *EU Istanbul Convention* on domestic and sexual violence against women

<sup>4</sup> *The UN Principles for Older Person's (1991)* can be accessed at:

<http://www.un.org/documents/ga/res/46/a46r091.htm>

at its core, in particular, respect for the right of the individual to make their own informed choices and decisions. A person-centred approach should result in the individual making informed choices about how he or she wants to live and about what services and supports will best assist them, with cognitive and communication support being provided where necessary. Where the person lacks capacity to make a decision, best interest decisions should be made by professionals which take all available information into account, including information about previously expressed preferences or choices made by the person being safeguarded.

**A Consent-Driven Approach:** To make a presumption that the adult has the ability to give or withhold consent; to make informed choices; to help inform choice through the provision of information, and the identification of options and alternatives; to have particular regard to the needs of individuals who require support with communication, advocacy or who lack the capacity to consent; and intervening in the life of an adult against his or her wishes only in particular circumstances, for very specific purposes and always in accordance with the law.

Consideration of consent is central to adult safeguarding in determining the ability of an adult at risk to make lifestyle choices, including choosing to remain in a situation where they risk being harmed; determining whether a particular act or transaction is harmful or consensual; and determining to what extent the adult can and should be asked to take decisions about how best to deal with a given safeguarding situation. For consent to be valid, the decision needs to be informed, made by an individual with capacity to make decisions and made free from coercion, constraint or undue influence. Each decision must be considered on its own merits as an adult may possess capacity to make some decisions but not others and/or the adult's lack of capacity to make decisions may be temporary rather than permanent. A consent-driven approach to adult safeguarding will always involve making a presumption that the adult at the centre of a safeguarding decision or action has the capacity to give or withhold consent unless it is established otherwise (see section 12).

**A Collaborative Approach:** To acknowledge that adult safeguarding will be most effective when it has the full support of the wider public and of safeguarding partners across the statutory, voluntary, community, independent and faith sectors working together and is delivered in a way where roles, responsibilities and lines of accountability are clearly defined and understood. Working in partnership and a person-centred approach will work hand-in-hand.

Harm resulting from abuse, exploitation or neglect can be experienced by adults in a range of circumstances, regardless of gender, age, class or ethnicity. Adults who are at risk, suitably supported, must be central to the partnership, either as participants in preventative activities or protection intervention, or as contributors to decision-making in connection with the development of safeguarding policy, strategy and procedures. Where it is not possible for the adult at risk to contribute directly as participants or contributors, consideration must be given as to how they can be suitably supported to ensure that they are involved at an appropriate level. Successful adult safeguarding requires effective arrangements for all involved to work together. The strength of a collaborative approach will depend on the commitment and support from the highest level to safeguarding adults at the highest level.

## 5. KEY DEFINITIONS

The risk of harm occurs in all socio-economic, racial and ethnic groups, regardless of gender, age or sexual orientation. All adults at risk should be supported and empowered to minimise their own exposure to risk and to find their own balance between taking risks and making the most of the strengths in their own life circumstances.

The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

An '**Adult at risk of harm**' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

- a) **personal characteristics**

**AND/OR**

- b) **life circumstances**

**Personal characteristics** may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. **Life circumstances** may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

An '**Adult in need of protection**' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

- a) **personal characteristics**

**AND/OR**

- b) **life circumstances**

**AND**

- c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

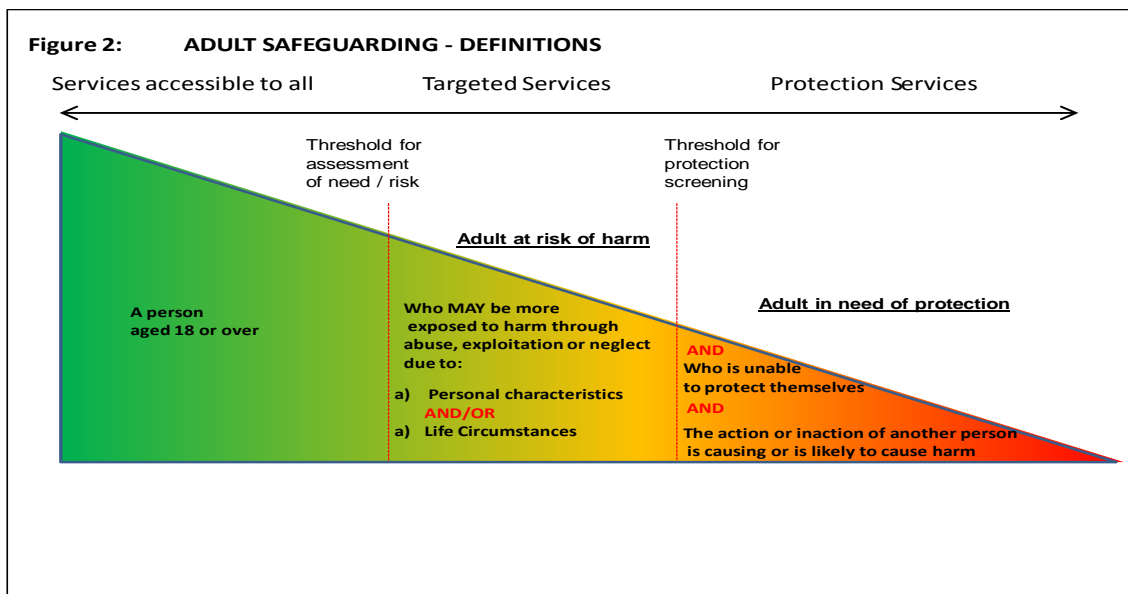
**AND**

- d) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

In order to meet the definition of an ‘adult in need of protection’ either (a) or (b) must be present, in addition to both elements (c), and (d).

The decision as to whether the definition of an ‘adult in need of protection’ is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Figure 2 below shows where the definitions sit on the continuum of adult safeguarding activity.



**Harm** is the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or well-being.

The full impact of harm is not always clear from the outset, or even at the time it is first reported. Consideration must be given not only to the immediate impact of harm and risk to the victim, but also the potential longer term impact and the risk of future harm.

Harmful conduct may constitute a criminal offence or professional misconduct.

A number of factors will influence the determination of the seriousness of harm. A single traumatic incident may cause harm or a number of ‘small’ incidents may accumulate into ‘serious harm’ against one individual, or reveal persistent or recurring harm perpetrated against many individuals.

The judgement of what constitutes '**serious harm**' is a complex one and demands careful application of professional judgement against a number of criteria. Assessments conducted by or on behalf of statutory HSC professionals (see section 10) should include consideration of the following:

- a) the impact on the adult at risk;
- b) the reactions, perceptions, wishes and feelings of the adult at risk;
- c) the frailty or vulnerability of the adult at risk;
- d) the ability of the adult at risk to consent and participate in the decision making process;
- e) the illegality of the act(s);
- f) the nature, degree and extent of harm;
- g) the pattern of the harm-causing behaviour;
- h) previous incidents, including any previous HSC Trust involvement
- i) the level of threat to the adult at risk's right to independence;
- j) the apparent intent of the alleged perpetrator and extent of premeditation;
- k) the relationship between the alleged perpetrator and the adult at risk;
- l) the context in which the alleged harm takes place;
- m) the risk of repetition or escalation of harm involving increasingly serious acts relating to this individual or other adults at risk; and
- n) the factors which mitigate the risk through service provision or wider arrangements.

There are no absolute criteria for judging when harm has become 'serious harm'; however this decision should include consideration of the degree, severity, duration and frequency of harm. The seriousness of harm depends on the impact experienced by the individual. Particularly careful consideration must be given to cases where the adult is unable to understand the impact harm is having on them. This will demand the application of professional judgement to consider all of the available evidence, the concerns and the wishes of the individual and to determine the seriousness of harm and the most appropriate intervention.

**Abuse** is 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'<sup>5</sup>.

Abuse is the misuse of power and control that one person has over another. Abuse may be perpetrated by a wide range of people, including those who are usually physically and/or emotionally close to the individual and on whom the individual may depend and trust. This may include, but is not limited to, a partner, relative or other family member, a person entrusted to act on behalf of the adult in some aspect of their affairs, a service or care provider, a neighbour, a health or social care worker or professional, an employer, a volunteer or another service user. It may also be perpetrated by those who have no previous connection to the victim.

<sup>5</sup> Action on Elder Abuse: definition of abuse 1993 which can be accessed at: <http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html>. This was later adopted by the World Health Organisation - [http://www.who.int/ageing/projects/elder\\_abuse/en/](http://www.who.int/ageing/projects/elder_abuse/en/)



The main forms of abuse are:

### **Physical abuse**

Physical abuse is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This may include hitting, pushing, rough handling, exposure to heat or cold, force feeding, improper administration of medication, denial of treatment, misuse or illegal use of restraint and deprivation of liberty.

### **Sexual violence and abuse**

Sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding<sup>6</sup>. Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping). Sexual violence can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

### **Psychological / emotional abuse**

Psychological / emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, humiliation or ridicule, provoking fear of violence, shouting, yelling and swearing, blaming, controlling, intimidation and coercion.

### **Financial abuse**

Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not or could not consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property or inheritance.

### **Institutional abuse**

Institutional abuse is the mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use. This can occur in any organisation, within and outside the HSC sector. Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place.

<sup>6</sup> The definitions of 'sexual violence and abuse' and 'domestic violence and abuse' will be amended to reflect those included within their revised strategies once published.

**Neglect** occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult. It may be through a lack of knowledge or awareness, or through a failure to take reasonable action given the information and facts available to them at the time. It may include physical neglect to the extent that health or well-being is impaired, administering too much or too little medication, failure to provide access to appropriate health or social care, withholding the necessities of life, such as adequate nutrition, heating or clothing, or failure to intervene in situations that are dangerous to the person concerned or to others particularly when the person lacks the capacity to assess risk.

This policy does not include self harm or self neglect within the definition of an 'adult in need of protection'. Each case will require a professional Health and Social Care (HSC) assessment to determine the appropriate response and consider if any underlying factors require a protection response. For example self harm may be the manifestation of harm which has been perpetrated by a third party and which the adult feels unable to disclose.

**Exploitation** is the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity. It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human trafficking.

This list of types of harmful conduct is not exhaustive, nor listed here in any order of priority. There are other indicators which should not be ignored. It is also possible that if a person is being harmed in one way, he/ she may very well be experiencing harm in other ways.

## 5.1. Related Definitions

There are related definitions which interface with Adult Safeguarding, each of which have their own associated adult protection processes in place.

### **Domestic violence and abuse**

Domestic violence and abuse is threatening behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on one person by another where they are or have been intimate partners or family members, irrespective of gender or sexual orientation. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

### **Human trafficking**

Human trafficking involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking can come from all walks of life; they can be male or female, children or adults, and they may come

from migrant or indigenous communities.

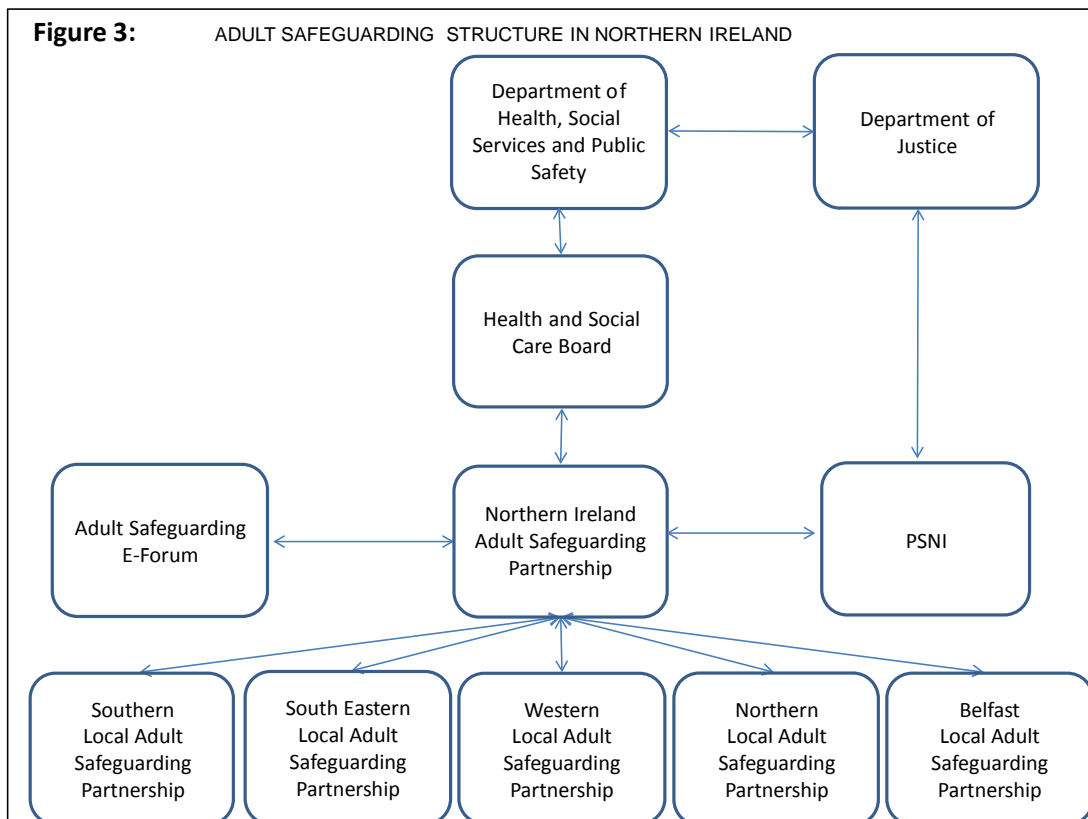
**Hate crime**

Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

Victims of domestic violence and abuse, sexual violence and abuse, human trafficking and hate crime are regarded as adults in need of protection. There are specific strategies and mechanisms in place designed to meet the particular care and protection needs of these adults and to promote access to justice through the criminal justice system. It is essential that there is an interface between these existing justice led mechanisms and the HSC Trust adult protection arrangements described in this policy.

## 6. THE ADULT SAFEGUARDING INFRASTRUCTURE

The **Northern Ireland Adult Safeguarding Partnership (NIASP)** and five **Local Adult Safeguarding Partnerships (LASPs)** were established under the Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements (2010)<sup>7</sup>. They are collaborative partnerships with a responsibility for adult safeguarding in Northern Ireland. The partnerships are tasked by DHSSPS, with the support of the DOJ, with the delivery of improved adult safeguarding outcomes by way of a strategic plan<sup>8</sup>, operational policies and procedures and effective practice, which will be developed and implemented in accordance with this policy. An outline of the structure is provided in Figure 3 below.



### 6.1. The Northern Ireland Adult Safeguarding Partnership (NIASP)

The NIASP is a regional collaborative body led by the Health and Social Care Board (HSCB). It is supported in its work by all its constituent members, who have made a commitment to adult safeguarding. The membership is drawn from the main statutory, voluntary, community, independent and faith organisations involved in adult safeguarding across the region and includes representation from service providers and users. The NIASP is responsible for promoting and supporting a co-ordinated

<sup>7</sup> *Adult Safeguarding in Northern Ireland – New Regional and Local Partnership Arrangements – March 2010* can be accessed at: [http://www.dhsspsni.gov.uk/asva-march\\_2010.pdf](http://www.dhsspsni.gov.uk/asva-march_2010.pdf)

<sup>8</sup> The *NIASP Strategic Plan* can be accessed at: <http://www.hscboard.hscni.net/NIASP/Publications/NIASP%20-%20Strategic%20Plan%202013-2018.pdf>

and multi-agency approach and for creating a culture of continuous improvement in adult safeguarding practice and service responses. The NIASP strategy promotes ownership of adult safeguarding issues within all partner organisations and across all professional groups and service areas.

The HSCB has lead responsibility for the effective working of the NIASP, which is chaired by the Director of Social Care and Children's Services, or a nominated deputy. The Chair ensures that safeguarding matters are brought to the attention of the appropriate Directors in the HSCB and the Public Health Agency (PHA). The Chair is accountable to the HSCB and is responsible for ensuring that there are robust governance arrangements in place and compliance with the HSCB's responsibility for Delegated Statutory Functions.

Each member representative is accountable to their employing organisation and should be of sufficient seniority to bring adult safeguarding issues to the attention of NIASP and to make decisions on behalf of their organisation. Each representative should ensure that any actions and decisions taken by the NIASP are shared and implemented as appropriate within their organisation.

## **6.2. Local Adult Safeguarding Partnerships (LASPs)**

The five LASPs are located within, and accountable to, their respective HSC Trusts. Their role is to implement the NIASP Strategic Plan, policy and operational procedures locally. Each LASP has responsibility to promote all aspects of safeguarding activity in its area and to promote multi-disciplinary, multi-agency and interagency cooperation, including the sharing of learning and best practice. They will be visible within, and engage locally with, communities to raise the profile of adult safeguarding.

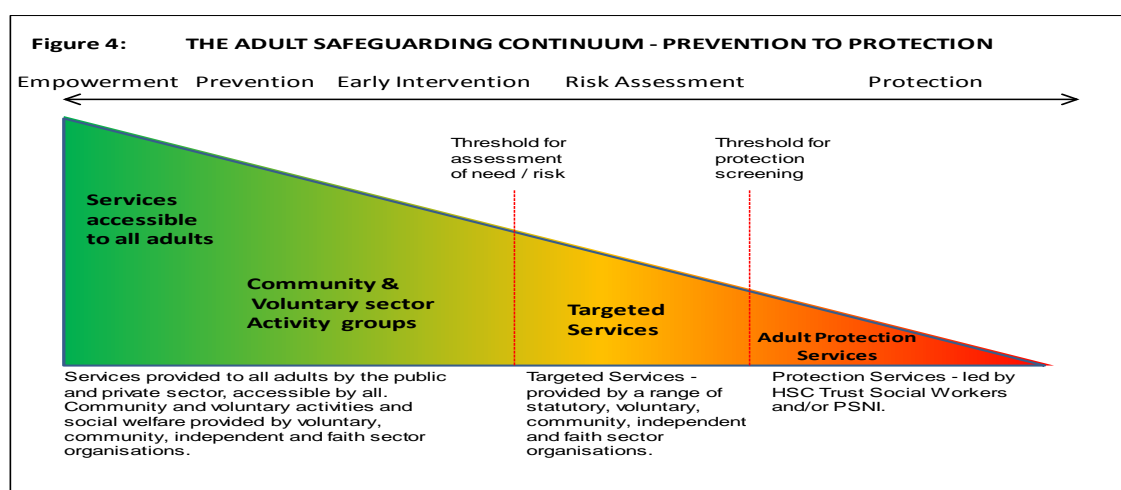
The LASP is chaired by the HSC Trust's Executive Director of Social Work or a senior designated nominee. It is responsible for ensuring that there are robust governance arrangements in place and ensuring compliance with the agreed statutory functions delegated by the HSCB.

Each partner organisation should be represented at a sufficiently senior level so that the LASP is effective in the implementation of guidance, policy and procedures at a local level, including engagement with service users, families, carers and the wider public. Each representative should be sufficiently senior to represent his/her organisation's views, to make decisions on its behalf and to ensure that safeguarding issues are dealt with in line with the organisation's established governance arrangements. Each representative should ensure that any actions and decisions taken by the LASP are shared and implemented as appropriate within their organisation.

## 7. THE CONTINUUM OF SAFEGUARDING – PREVENTION TO PROTECTION

Safeguarding is a broad continuum of activity. It ranges from the empowerment and strengthening of communities, through prevention and early intervention, to risk assessment and management, including investigation and protective intervention. At all stages along this continuum, safeguarding interventions will aim to provide appropriate information, supportive responses and services which become increasingly more targeted and specialist as the risk of harm increases. Presenting safeguarding activity in this way is intended to reflect the importance of prevention and early intervention, both as a means of improving the safety and quality of life and outcomes for all adults and reducing the risks of incidents of harm and need for more intrusive protection interventions. This is not intended to suggest that any stage or intervention along the continuum is mutually exclusive of the others. Throughout the continuum it is essential to recognise the importance of promoting empowerment and self-determination and the rights of all adults to make informed lifestyle choices.

Figure 4 below shows adult safeguarding interventions as a continuum of activity.



**Local communities and services provided to the adult population** are the starting point of the adult safeguarding continuum. Individuals will in the first instance be supported by their families and friends and by local community involvement and support. Using community development approaches, and working in partnership with local communities and organisations, we must build stronger, self-reliant communities and effective working relationships that promote people's rights, challenge inequalities and improve local support. Building safer communities involves helping adults to minimise their own exposure to the risk of harm from abuse, exploitation or neglect by empowering, equipping and enabling them to keep themselves safe, while at the same time enabling them to live their lives and pursue their interests to the fullest extent possible. Within communities there are a range of public and private services which will be available to and accessed by all adults.

This policy advocates that where there are potential interfaces with adults who may be at risk of harm, the organisations delivering such services should consider how adult safeguarding may be relevant to them and the actions they can take to prevent harm arising from abuse, exploitation or neglect to those using their services.

Within communities there are **recreational social, sporting or educational activities** available to all adults provided by a range of organisations across the statutory, voluntary, community, independent and faith sectors. Organisations providing these activities contribute to safeguarding adults by ensuring that these activities are delivered in a way which keeps adults safe. These organisations will need to assure themselves and everyone who comes in contact with them, that the organisation is committed to best safeguarding practice and to uphold the rights of all adults to live a life free from harm from abuse, exploitation and neglect. These organisations should have in place a culture of zero-tolerance of harm to adults which necessitates: the recognition of adults who may be at risk and the circumstances which may increase risk; knowing how adult abuse, exploitation or neglect manifests itself; and being willing to report safeguarding concerns. This extends to recognising and reporting harm experienced anywhere, including in the person's own home, in any care setting, in the community, and within organised community or voluntary activities (see section 8).

Voluntary, community, faith and independent service and/or activity providers are at the forefront of **preventative** safeguarding responses within the community. To be effective, preventative safeguarding requires everyone in society to work as partners, that is, individuals, families, carers, professionals and agencies working together to keep individuals safe and to prevent harm from abuse, exploitation or neglect.

One of the key ways of preventing escalation of the risk of harm is to intervene early. **Early intervention** is part of the safeguarding continuum and provides help and support to prevent problems reaching a point where a protection response becomes necessary.

In circumstances where community based activities can no longer meet the needs of an adult, or where there are emerging safeguarding concerns, contact should be made with the local HSC Trust for a professional **assessment of needs and/or risks**. All actions or interventions must be person centred and put the adult in need or at risk of harm at the centre of decision making.

If the concern relates to serious harm a referral may be made directly to the Adult Protection Gateway Service.

Very often it is the General Medical Practitioner (GP) who will be the first point of contact for adults and their families where an individual's needs are changing and they require further support. GPs and other allied health professionals, such as opticians, pharmacists, dentists or therapists, have a key role in the identification of risks of harm and ensuring appropriate referral to the HSC Trust for a further assessment of needs and/or risks.

**Targeted services** are services delivered specifically to 'adults who may be at risk' in order to meet assessed needs and/or address risks. The scale and intensity of service provision and intervention is likely to increase in proportion to the level of assessed need or risk. As the level of need or risk increases HSC Trusts may need to take action to prevent or manage any identified need or risk of harm, through provision of a service such as domiciliary based care, supported living, residential or nursing care. Targeted services will normally be delivered by, commissioned or contracted by, HSC Trusts. However voluntary, community, independent and faith

sector organisations may provide services targeted specifically at groups of adults at risk for recreational, social, sporting or educational purposes.

Targeted services include all services which fall under the definition of Regulated Activity contained within Schedule 2 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007<sup>9</sup>. This includes all health and social care services, whether delivered by statutory or independent providers, such as hospitals and GPs.

Many adults at risk will spend most of their time where they live, particularly those adults with restricted mobility and/or limited capacity to make decisions. These people may be more heavily dependent upon targeted services and the support of others, and their level of risk may increase as they spend much of their time in their home, often alone, or with the same people surrounding them, and with greater dependency on individuals or carers.

All targeted service providers, must be zero-tolerant of harm. There is an expectation that providers of targeted services will have robust governance and safeguarding procedures in place within their organisations to ensure that care is delivered in a way which instils confidence amongst those who use the service, staff, management, regulators and the public.

There is an expectation that commissioners of services will require, by way of service level agreements or contracts, the providers of targeted services to have robust governance and safeguarding regimes in place. There is an expectation that as employers, both service providers and commissioners must also ensure their organisations promote zero-tolerance of harm to adults within the workplace.

As the risk of harm increases, the safeguarding response required to mitigate it also increases. At the higher end of the safeguarding continuum is the **Adult Protection Gateway Service**. This service is provided for 'adults in need of protection', that is, those adults for who harm from abuse, exploitation or neglect, is a reality either because it has already occurred or, without intervention, is at serious risk of occurring. Protection interventions are led by social workers within the HSC Trusts and/or PSNI officers; the latter primarily where a crime or criminal act is alleged or suspected. These lead agencies will engage with the adult in need of protection in the first instance. They will also require information, action and support from other disciplines, agencies and organisations to assist with an adult protection or criminal investigation, or to contribute to the development and delivery of a care and protection plan for an adult in need of protection.

<sup>9</sup> The SVG Order can be accessed at: <http://www.legislation.gov.uk/nisi/2007/1351/contents>



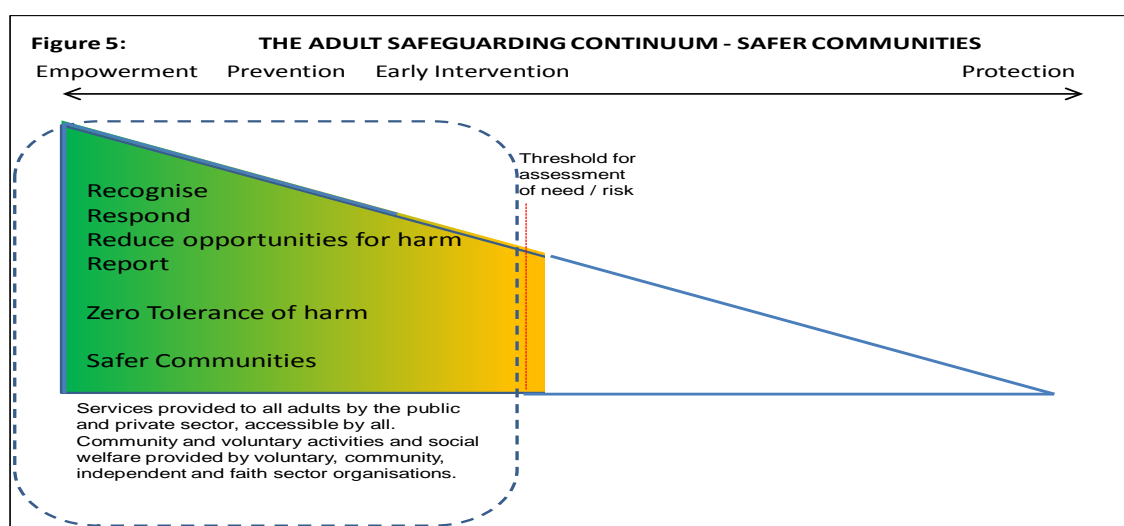
## 8. PREVENTION – PROMOTING SAFER COMMUNITIES AND SAFER ORGANISATIONS

The prevention of harm requires the promotion and creation of:

- **safer communities**, that is, safe places for all adults to live in, including those who may be at risk; and
- **safer organisations**, that is, safe places where all adults, including those who may be at risk, access and receive services or participate in organised activities.

Whether living in communities or working or volunteering in organisations, each of us needs to be zero-tolerant of potentially harmful behaviours against others, and when we suspect something is wrong, to report it (see section 10).

Figure 5 shows where safer communities sit on the Adult Safeguarding continuum.



### 8.1. Safer Communities

A key objective of this policy is to promote safer communities for adults to live in and safer organisations for them to be actively part of. The more socially isolated people are the greater the risk of harm arising from abuse, exploitation or neglect. The creation of safer communities for all adults is the responsibility of central and local government; of statutory sector service providers; and of voluntary, community, independent and faith sector providers. Local communities, neighbours and citizens also have a key role to play.

Empowerment is key to the promotion of safer communities and the prevention of harm. We should seek to connect people with the resources, activities and services that promote involvement and minimise opportunities for people to cause harm to others. Communities should aim to create opportunities to encourage and empower people to participate as fully as possible in their communities and broader society. Safer communities can play a vital signposting role in connecting people with local resources and supports that enable them to resolve their own problems and challenges.

There are a number of strands to the creation of safer communities that will greatly contribute to the prevention of harm.

#### Effective Health and Social Care Policies and Strategies

Being fit and well means people are better placed to ensure their personal safety.

Initiatives which:

- aim to prevent slips, trips and falls;
- promote healthy eating, exercise and the sensible use of alcohol;
- ensure good dental and eye care;
- promote personal resilience, self awareness and independence;
- encourage and assist people where necessary to feel safe in their own home

all contribute to assisting people to be better able to address their personal well-being and safety. This requires effective health and social care planning and implementation, robust public health strategies and responses, and commissioning and delivery underpinned by standards frameworks<sup>10</sup> which set out the care that patients, clients, their carers and wider family can expect to receive.

#### Effective Community Safety Policies and Strategies

People who feel safe in their homes and community are more likely to feel in control of their lives and to take positive steps to ensure their personal safety. A number of types of crime – such as doorstep crime; distraction burglaries; bogus callers; rogue traders; cold callers and cyber crime are of particular concern with regard to adults at risk in our communities. The work of voluntary and community groups is critical to help adults who may be at risk to live safer lives and minimise their exposure to risk of harm through the promotion of local initiatives to provide information and support.

The 'Building Safer, Shared and Confident Communities – A Community Safety Strategy for Northern Ireland 2012-2017'<sup>11</sup> contains commitments to reduce fear of crime and help people to feel safer through regional and local programmes to increase trust and confidence. Through engagement with the voluntary and community sector, the strategy aims to:

- improve understanding of fear of crime and deliver tailored projects to reduce fear;
- promote intergenerational projects to bring old and young together to increase confidence;
- promote positive perceptions of young people; and
- engage with the media on reporting of crime and anti-social behaviour and its impact on fear and confidence.

The Policing and Community Safety Partnerships (PCSPs)<sup>12</sup> which operate in each council area are central to the delivery of safer communities. Each PCSP works with its local community to identify and address issues of concern in the local area and

<sup>10</sup> Frameworks for Mental Health and Wellbeing, Learning Disability and Older People's Health and Wellbeing can be accessed at: [http://www.dhsspsni.gov.uk/mhsf\\_final\\_pdf.pdf](http://www.dhsspsni.gov.uk/mhsf_final_pdf.pdf)  
[http://www.dhsspsni.gov.uk/learning\\_disability\\_service\\_framework\\_june\\_2013.pdf](http://www.dhsspsni.gov.uk/learning_disability_service_framework_june_2013.pdf)  
[http://www.dhsspsni.gov.uk/service\\_framework\\_for\\_older\\_people-2.pdf](http://www.dhsspsni.gov.uk/service_framework_for_older_people-2.pdf)

<sup>11</sup> <http://www.dojni.gov.uk/community-safety-strategy-2012-2017.htm>

<sup>12</sup> Further information on PCSPs can be obtained from [www.pcsp.org](http://www.pcsp.org)

PCSP Policing Committees work with local PSNI to develop local policing plans and monitor their performance in enhancing community safety in their area. They also work to secure the co-operation of the public to prevent crime and enhance community safety.

#### Effective Awareness of Adult Harm and Abuse and Responsibility to Report

Adult abuse is underreported. People may not report their concerns for a number of reasons, including not recognising it for what it is or fear of 'getting it wrong'. It is a reality that the adult who is at risk is often dependent on the person whose behaviour is, either intentionally or unintentionally, causing the harm.

Public awareness campaigns and education programmes can help the public to recognise that adult harm and abuse is unacceptable in a civilised society and encourages the reporting of concerns to the HSC Trust and the Adult Protection Gateway Service. Education programmes in schools and colleges encompassing 'good citizenship' principles and social responsibilities can help begin the shift towards a society which is zero-tolerant of adult harm.

Many public and private service providers within the community are well placed to identify early indications that an adult may be at risk, for example banks or legal services such as solicitors. Providers of services who are in a position of trust, in particular GPs and providers of primary care services, will have access to information regarding adults which may suggest they are at risk of harm. Service providers should be aware of the signs of harm to adults within their respective sectors, and should ensure organisational procedures are in place to guide staff when concerns are identified. All those working to provide services to the community generally have a responsibility to refer concerns to their local HSC Trust, and to cooperate and share information where necessary with any adult safeguarding investigations.

## 8.2. Safer Organisations

The continuum of adult safeguarding outlines the wide range of organisations involved in people's lives, from the small community activity groups through to larger organisations and statutory services. All organisations should ensure that any service they deliver is underpinned by the principles of respect and treating others with dignity (see section 4). This is the first and crucial step to ensuring that services are high quality, that the focus is on the individual receiving the service which may help to provide support and that harm is prevented. Increasing levels of need and risk are likely to lead to greater targeting of service provision, which, in turn, requires a heightened awareness of risk of harm and more robust measures will be required to prevent harm.

Robust governance arrangements are key to an organisation's ability to keep adults safe from harm. A range of governance arrangements exist, which should not and cannot operate in isolation. No single governance measure will ensure the safety of adults at risk. Both internal governance and external measures are vital to ensure that safeguarding concerns are identified early and escalated to enable appropriate action to be taken. Governance arrangements must be brought together to provide a level of assurance to managers and leaders that the organisation is doing all it can to keep adults in receipt of its services safe from harm.

Each organisation will have its own internal governance arrangements depending on the size of the organisation and the nature of its activities. The governance arrangements should be proportionately robust to enable managers at all levels, including the Chief Executive and Board members where applicable, to assure themselves that the organisation is delivering a safe, high quality service to all, and that it is effectively adhering to the adult safeguarding expectations appropriate to the organisation.

Senior managers should create a culture where staff and volunteers feel that their role and contribution is valued and that they are empowered, and supported in decision making by line managers. Senior management must ensure good governance is cascaded throughout the organisation. Line managers should ensure decisions taken by their staff which relate to adult safeguarding are consistent with organisational safeguarding policies.

Where an organisation permits, by way of contracts or otherwise, the use of its facilities or services by third parties to provide services or activities to adults, assurances should be sought from the third party that it is adhering to the appropriate level of governance as described below.

### **8.3. Minimum Safeguarding Expectations**

At a minimum, any public service, voluntary, community, independent or faith organisation providing recreational social, sporting or educational activities or services will be expected to safeguard adults who may be at risk by:

- **recognising** that adult harm is wrong and that it should not be tolerated;
- **being aware** of the signs of harm from abuse, exploitation and neglect;
- **reducing opportunities for harm** from abuse, exploitation and neglect to occur; and
- **knowing how and when to report** safeguarding concerns to HSC Trusts or the PSNI.

### **8.4. Internal Governance – Policy and Procedures**

The following policies and procedures are the building blocks of good governance that contribute to safe high quality care and they should be robustly implemented by any organisation.

These are essential for any organisation delivering, commissioned or contracted to deliver targeted services.

- Robust selection and recruitment procedures;
- Effective management, support, supervision and training of staff;
- Procedures for responding to, recording and reporting safeguarding concerns in a timely manner to the HSC Trusts;
- Procedures for cooperating within the organisation and with others as required to address safeguarding concerns;
- Procedures for assessing and managing risks;
- Management of reporting and escalating untoward/adverse incidents;

- Procedures for managing comments, complaints and suggestions;
- Procedures on the management of records, confidentiality, and the sharing of information, (see section 14);
- A written code of behaviour/conduct;
- A disciplinary policy, including referral to regulatory bodies where relevant; and
- A whistle-blowing policy.

## Care and Service Standards

All providers of targeted services are required to have in place the above governance arrangements and, depending on the nature and level of the service delivered, providers may also be required to ensure compliance with care and/or service standards and regulations against which they will be inspected or audited. Where there are breaches in compliance with standards or regulations and the quality of care or the safety of service users is compromised, the role of inspection and that of the relevant regulator is critical in addressing the safeguarding concern and the prevention of harm.

All organisations providing targeted services to adults who may be at risk must have the above governance arrangements in place, supported by the implementation of an adult safeguarding policy.

## Adult Safeguarding Policy

The **Adult Safeguarding Policy** will clearly demonstrate the organisation's commitment to a zero tolerance of adult harm. The policy must be owned and supported by senior management and be accessible to all within the organisation.

A key element of the adult safeguarding policy will be the nomination of **Adult Safeguarding Champions** (ASC)<sup>13</sup>. An ASC must be accessible to all service areas in the organisation as a source of advice and guidance. The nominated ASCs should be senior people within the organisation, suitably trained, experienced and skilled to carry out the role (see section 15).

The role of the **Adult Safeguarding Champion** is:

- to provide information and support for staff on adult safeguarding within the organisation;
- to ensure that the organisation's adult safeguarding policy is disseminated and support implementation throughout the organisation;
- to advise within the organisation regarding adult safeguarding training needs;
- to provide advice to staff or volunteers who have concerns about the signs of harm, and ensure reporting to HSC Trusts where there is a safeguarding concern (see section 10);
- to support staff to ensure that any actions take account of what the adult wishes to achieve – this should not prevent information about any risk of

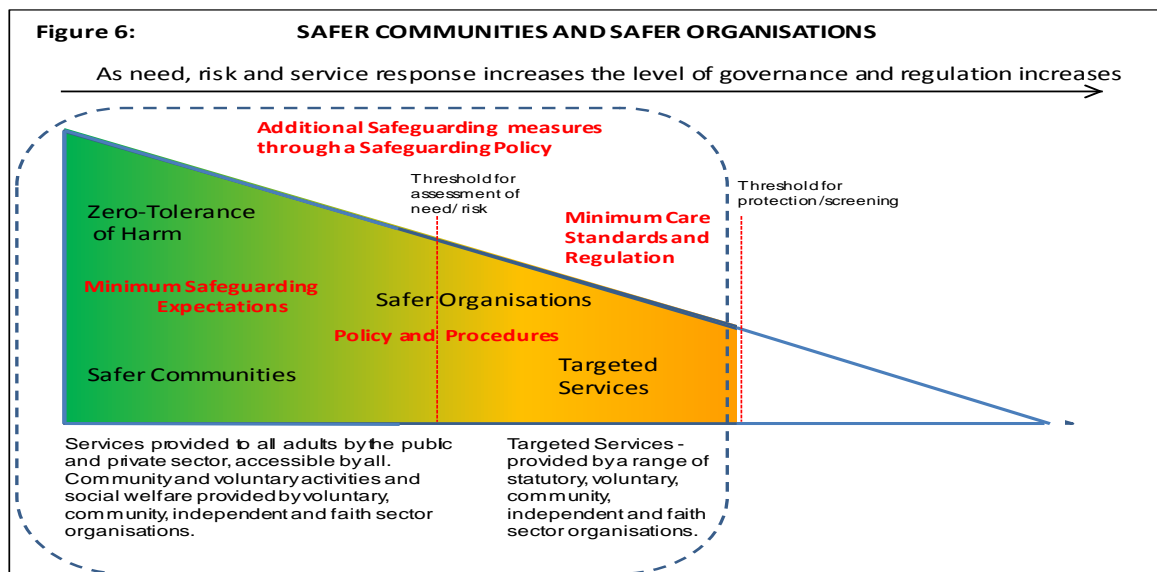
<sup>13</sup> The term Adult Safeguarding Champion is intended to encompass the roles of the 'Nominated Manager' referred to in the Volunteer Now Standards and Guidance document 'Safeguarding Vulnerable Adults – a Shared Responsibility' and the role of the 'Alerting Manager' in the NIASP Adult Safeguarding Strategic Plan 2013-2018.

serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision-making;

- to establish contact with the HSC Trust Designated Adult Protection Officer (DAPO) (see section 11), PSNI and other agencies as appropriate;
- to ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken;
- to compile and analyse records of reported concerns to determine whether a number of low-level concerns are accumulating to become significant; and make records available for inspection.

Where the ASC is not immediately available, this should not prevent action being taken or a referral being made to the HSC Trust in respect of any safeguarding concern.

Figure 6 below shows the relationship between safer communities, safer organisations and the increasing governance arrangements.



As the level of need or risk and service intervention increases, more robust governance measures and requirements will apply.

## 9. EXTERNAL GOVERNANCE

### 9.1. Commissioning/ Subcontracting Arrangements

Services for adults at risk may be commissioned or sub-contracted by a range of organisations across the statutory, voluntary, community, independent or faith sectors. This may include, for example, commissioning by the NIHE, local councils, PSNI and other justice organisations, or the HSC sector. Any organisation which commissions or sub-contracts provision of a service for adults at risk to another third party organisation retains responsibility and accountability for the quality of the provision of that service.

The HSCB, HSC Trusts and the PHA may commission or purchase health and social care services from third party providers, whether from the voluntary, community, independent or faith sectors. This will include GP and other primary or health care services, such as private hospitals, nursing or residential care, supported housing, day care or domiciliary care services.

It is critical that all commissioning or subcontracting organisations ensure that it is a condition of all contracts or service level agreements with service providers that there are robust governance arrangements in place within those provider organisations to ensure that adults at risk are safe from harm and receive a high quality service.

HSC Trusts must provide advice and guidance to adults who may be at risk who are commissioning their own care, for example those in receipt of direct payments or self directed support, outlining what they should expect from their service provider in terms of governance arrangements and good safeguarding practice.

Those who have a role in the management and monitoring of **contracts** have a responsibility:

- to specify and issue contracts for the purchase of services commissioned to address identified needs;
- to acquire and maintain a sufficient level of knowledge about adult safeguarding relevant to their role;
- to require that all services meet their safeguarding requirements described in this policy and other standards of quality set by the DHSSPS;
- to work closely with service providers to assist them to address ongoing concerns that may relate to contractual/service level agreement requirements;
- to monitor the quality of the performance of service providers and identify any deterioration in standards of care and risks this may present;
- to regularly audit the third party service provider to ensure the service is being delivered in accordance with the contract and this policy;
- to escalate any concerns about the provision of care to the care manager / key worker or senior management; and
- where requirements are not being met, to use appropriate reporting mechanisms to ensure adults at risk are kept safe, and where necessary impose appropriate sanctions.

All professionals with responsibility for carrying out the **care management** process and function must:

- ensure that needs and risks to the adult at risk are identified and assessed, taking account of their views and preferences;
- ensure that there is a personalised care plan detailing the needs of the adult and specifying how the service provided will safely meet the needs and mitigate any risks identified;
- ensure the care plan is being implemented as agreed by the service provider;
- ensure that the care plan is reviewed regularly, as specified in the Care Management Guidance, or more frequently as required in order to respond to changing needs and/or risks;
- ensure a safe and high quality service is provided, noting any patterns emerging which suggest that there may be a cause for concern and acting upon any such concerns;
- ensure that they are informed of any incidents, accidents or “near misses” in respect of the individuals for whom they have commissioned care;
- ensure that they are informed of any changes in financial circumstances that come to the attention of the HSC Trust;
- ensure that they are informed of any complaints made and action taken to address them;
- analyse trends to identify patterns which may indicate low-level concerns or poor quality care issues which may accumulate to indicate that there is a risk of harm; and
- escalate concerns which may indicate serious harm or risk of serious harm to an adult at risk (see section 10).

## 9.2. Professional Regulation

Regulatory bodies are responsible for establishing and operating statutory schemes of regulation underpinned by professional standards and Codes of Conduct relating to the conduct and practice of their respective professions. They maintain registers of workers who meet those standards and this information is publicly available. Within the health and social care sector for example, doctors, nurses, social workers and allied health professionals must register with their respective regulatory body before being able to practice. Where risks of harm to a service user are identified, all professionals must act in accordance with any professional Code of Conduct agreed with their regulatory body.

A person who is the subject of an investigation by their regulatory body may also be under investigation in respect of an adult protection investigation. Where both investigations run in parallel, the adult protection investigation must take precedence to ensure that the rights and safeguarding needs of adults at risk are being protected and the integrity of any criminal investigation is maintained.



### 9.3. Legal Requirements

Where there are statutory requirements linked to safeguarding or quality of service provision, all organisations will need to be assured that they are fully compliant with the requirements of the law.

Of particular relevance to adult safeguarding is the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, which seeks to protect children and vulnerable adults from harm caused by those who work closely with them. Schedule 2 of this Order contains a definition of Regulated Activity, and anyone engaging in Regulated Activity should have their suitability checked through AccessNI prior to employment.

The **Disclosure and Barring Service**<sup>14</sup> (DBS) is responsible for maintaining the list of individuals barred from engaging in Regulated Activity with children and vulnerable adults across England, Wales and Northern Ireland. A regulated activity provider must refer anyone to the DBS who has harmed or poses a risk of harm to a child or a 'vulnerable adult' and who has been removed from working (paid or unpaid) in regulated activity, or would have been removed had they not left. The DBS will decide whether the person should be barred from working in regulated activity with children, or adults, or both.

It is an offence to knowingly engage a barred person in regulated activity and it is an offence to engage or offer to engage in regulated activity if you are barred.

Within the health and social care sector, HSC Trusts, voluntary, community, independent and faith sector providers must be assured that they are fully compliant with the duty of quality imposed on them by the Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003<sup>15</sup> and the Regulations made under that Order.

### 9.4. Regulation

There is a broad range of regulators, auditors and inspectorates which are relevant to adult safeguarding. Each has a specific role in measuring and ensuring that organisations comply with their own particular service or quality standards and the regulatory framework within which they operate.

Regulation, inspection and audit should make clear the expectation that service providers must meet the relevant quality standards, detect failings in provision of care or services early, and take appropriate action when sub-standard care is found.

Regulation needs to be responsive and proportionate, with the aim of ensuring public confidence in the services provided. This can only be achieved by a highly coordinated, integrated and expert regulatory system employing intelligent and thoughtful inspection. It will require the ability to apply both qualitative and quantitative judgement and to take effective enforcement action when necessary.

<sup>14</sup> Information on the Disclosure and Barring Service can be accessed at:

<http://www.nidirect.gov.uk/disclosure-and-barring-protecting-children-and-vulnerable-adults>

<sup>15</sup> The 2003 Order can be accessed at: <http://www.legislation.gov.uk/nisi/2003/431/contents>

## **The Role of Regulation and Quality Improvement Authority (RQIA)**

The RQIA is the independent regulator of the health and social care sector and has an important role in promoting continuous improvement in the quality and safety of care delivered across the range of health and personal social services. RQIA registers and inspects a range of services described in the Health and Person Social Services (Quality, Improvement and Regulation) Order (Northern Ireland) 2003. These services are subject to regulation and are provided by both the statutory and independent sectors. RQIA's regulatory function operates within a framework of regulations and standards produced by DHSSPS.

RQIA inspections and reviews are conducted across a range of HSC settings in the statutory, independent and voluntary sectors. RQIA has a specific role in inspecting mental health and learning disability hospital wards. RQIA, through its inspections and reviews, makes an independent assessment of the safety, quality and availability of health and social care services. Within the regulated care sector, inspections may be announced or unannounced, and examine compliance with regulations and minimum standards in the areas of care, medicines management, estates and finance. Other inspections or reviews can be commissioned and conducted across a range of health and personal social services. Where the service inspected is not meeting the required quality standards, or where compliance issues or concerns are identified, there are a range of robust sanctions and powers available to RQIA.

The RQIA has a key preventative role in adult safeguarding practice. As the independent regulator, RQIA has both a responsibility and the authority to ensure that safety and quality of care concerns which put service users at risk are addressed in the services which they inspect. The RQIA also has a key role in service improvement with the aim of encouraging improvement in the quality of the services they inspect and securing public confidence in the provision of those services by keeping the Department of Health, Social Services and Public Safety informed of their availability and their quality.

Governance information is essential to RQIA in the conduct of its inspections and reviews. It assists with the assessment of the service with specific regard to safeguarding performance. There are core governance elements which should be included in all inspections conducted within regulated services. These are the number, nature and outcome of:

- complaints made;
- safeguarding concerns raised with the Adult Safeguarding Champions;
- notifiable incidents or accidents which occurred as appropriate to that service setting; and
- any disciplinary procedures conducted.

Information collected during inspections and other information which may come to the attention of the RQIA, from a range of sources, including statutory notifications, must be collated and analysed to ensure trends are identified. In particular, information on complaints, notifiable incidents and accidents should be triangulated as these are key indicators of risk to service users. Inspectors should be aware that a number of low-level concerns could suggest patterns or trends which accumulate to a risk of serious harm to one or more adults.

Enforcement action is an essential element of the responsibilities of RQIA. There is a range of enforcement options which RQIA can use to ensure compliance with regulations and minimum standards, to effect improvements and to afford protection to service users. In most circumstances, and where appropriate, RQIA will make recommendations and requirements for quality improvement through regulation and inspection activity. Where a service is identified as being at risk of failing to meet minimum standards and/or comply with regulations, RQIA will consider the various options to enable the registered establishment or agency to make the necessary improvements. RQIA will normally adopt a stepped approach to enforcement. However, this would not rule out the option of moving directly to legal action, including prosecution, if the circumstances require. RQIA may increase inspection activity to monitor compliance and ensure that the necessary improvements are being made. RQIA may escalate enforcement actions at any time, proportionately and in relation to the level of risk to service users and the seriousness of any breach of regulation. RQIA will follow up enforcement action to ensure that quality improvements are achieved. In certain circumstances, where there is deemed to be a risk of serious harm to service users, RQIA may take urgent action. Such circumstances include, but are not exclusive to, those falling under the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). This may involve, where necessary, using its powers to cancel registration and/or to seek the urgent closure of a registered service. RQIA publishes its enforcement policy and procedures online, along with copies of its inspection reports<sup>16</sup>.

The RQIA will notify any serious concerns in relation to the quality of service provision or risk of harm to an individual/s to the relevant HSC Trust or the PSNI, and will be a key partner contributing to investigations with the other agencies to protect adults at risk who are in receipt of a regulated service.

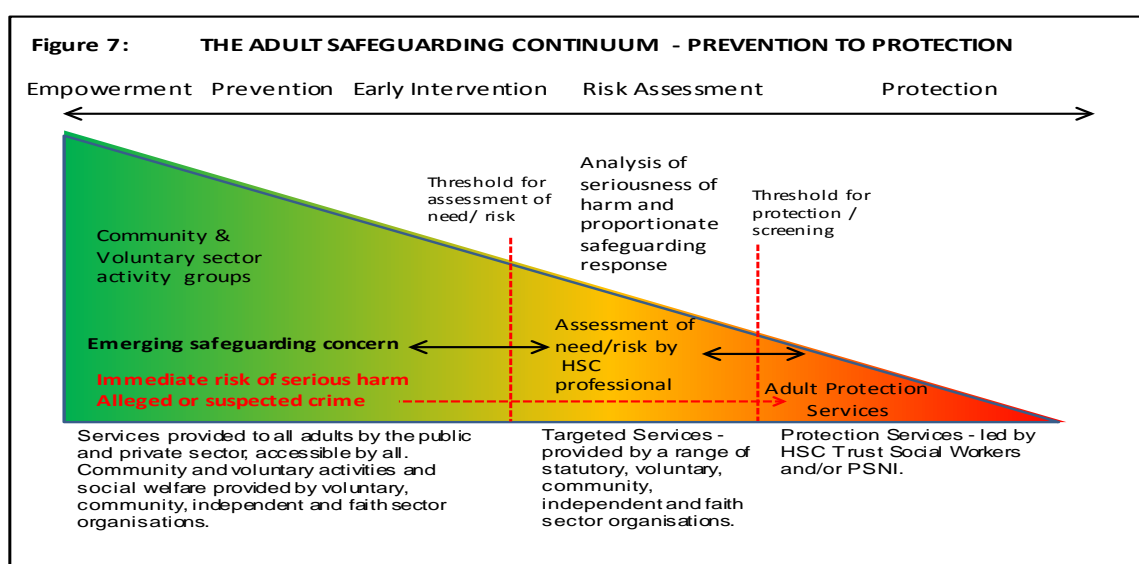
<sup>16</sup> RQIA publications are available on [www.rqia.org.uk](http://www.rqia.org.uk)

## 10. REFERRAL PATHWAY FOR SAFEGUARDING CONCERNS

If there is a clear and immediate risk of harm or a crime is alleged or suspected, the matter should be referred directly to the PSNI or HSC Trust Adult Protection Gateway Service.

However in most circumstances there will be an emerging safeguarding concern which should normally be referred to the HSC Trust, for a professional assessment. It will be a matter for HSC professionals to judge whether the threshold for an adult protection intervention has been met, or whether alternative responses are more appropriate. Referrals can be made from any source.

Figure 7 shows the pathway for reporting emerging safeguarding concerns through targeted HSC services and if necessary to the HSC Trust adult protection service.



All HSC Trusts must have a single point of access for receipt of referrals regarding concerns about adults who may be at risk, and will promote and publicise contact arrangements within its area. HSC Trust arrangements must accommodate referrals which do not obviously fit existing Programme of Care structures, ensuring there are no safeguarding gaps.

### 10.1. Risk Assessment

When any risk of harm is identified, a risk assessment must be undertaken to establish the degree of risk of harm to that individual and to others. It is the responsibility of suitably qualified statutory HSC professionals to undertake such risk assessments once a concern has been raised. In certain circumstances HSC Trusts may ask another organisation to conduct risk assessments on its behalf.

HSC professionals are required to put the individual's needs and wishes at the heart of the risk assessment process, and to use their expert skills and professional judgement so that the most appropriate and preferred course of action or outcome is found for each individual.

Assessment is a process which focuses on the individual and their circumstances at the time, recognising that needs and risks can change over time. Assessment will analyse and be sensitive to the changing levels of need and risk faced by an individual. It may require specialist assessments or expert opinion to inform the evidence gathering. All information should be analysed to determine the nature and level of risk. The assessment will inform a proportionate response based on the views and wishes and the preferred outcomes of the individual.

In gathering information to inform the assessment, professionals should be aware that this may also be required as part of a criminal investigation. Therefore it is critical to ensure that any potential evidence that may be later required by the PSNI is not compromised.

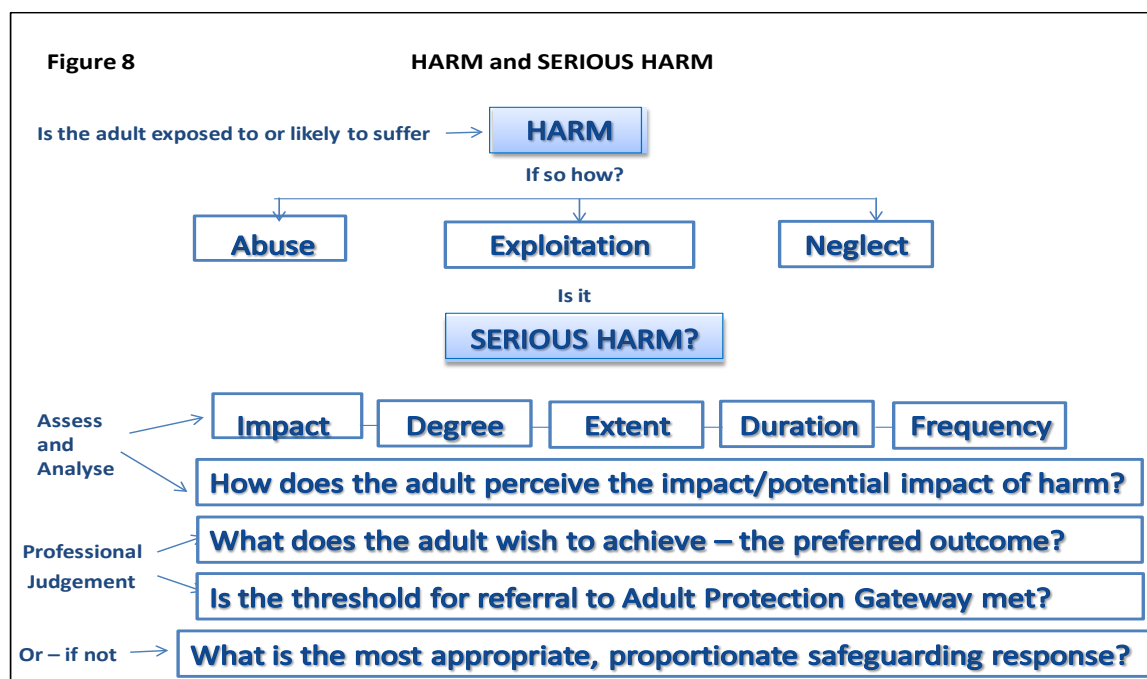
In making professional judgements, due regard should be given to the capacity of the adult to make informed choices, free from duress, pressure or undue influence and their capacity to make decisions to protect themselves from harm. All adults, including those at risk will always be assumed to have capacity to make decisions unless it has been determined otherwise (see section 12) and, ideally, a referral to the HSC Trust should be made with the adult's agreement and full participation. However, there may be circumstances in which the person concerned about an adult at risk may not be best placed to seek their consent to a referral being made, or the adult at risk is clearly stating that they do not want a referral to be made. Whilst the wishes of the adult should always be the paramount consideration, it is important to remember that there will be circumstances when other factors may be overriding, for example, where undue influence or coercion is suspected to have influenced the adult's decision or other people may be at risk. The inability to obtain an adult's consent in these circumstances should not prevent or delay concerns about that adult being reported to adult protection services. A balance must also be struck between an individual's human rights and the need to intervene to protect them from harming themselves or others.

Consideration should be given to the vulnerability of the alleged perpetrator. It is possible that a risk assessment may also be required for the perpetrator.

The analysis of risk will be central to decisions about future intervention. Any safeguarding intervention is not about being risk averse, nor simply about eliminating risk; adult safeguarding is about empowering and supporting people to make decisions that balance acceptable levels of risk in their lives. This may mean that individuals choose to live with risks or to take risks. The exercise of professional judgement in determining the level of risk of harm and whether a referral for an adult protection intervention is required is critical.

Where professionals have contact with an adult at risk they may have opportunities to identify risk of harm. Within the HSC sector this may be for example a GP, District Nurse, Social Worker or another Allied Health Professional, or may be within acute or hospital settings. Professionals must be alert to signs of harm and escalate their concerns to the Adult Protection Gateway Service with the local HSC Trust (see section 11).

Figure 8 illustrates the factors for consideration in determining whether harm has become 'serious harm'.



Where a risk assessment concludes that the adult is at risk of serious harm, or has experienced serious harm (see section 5), then consideration must be given to whether the threshold for referral to Adult Protection Gateway Service has been met.

## 10.2. Determining Whether the Thresholds for Referral to Adult Protection Gateway Service Are Met

In the majority of cases where serious harm has been identified, the thresholds for Adult Protection Gateway Service will be met. However it must be remembered that in some circumstances referral into the Adult Protection Gateway Service may not be the most appropriate response. This may include, for example, a peer on peer incident where capacity is an issue and alternative responses are more appropriate (see below). At all times the least intrusive and most effective response should guide the intervention. The following thresholds are intended as a guide.

Thresholds are not intended to be used as exclusion criteria, but should be used positively to assist professional judgements about making referrals into the HSC Trust Adult Protection Gateway Service, and, critically, to enable informed decisions in respect of the most appropriate or proportionate safeguarding response.

The threshold for referral to the HSC Trust Adult Protection Gateway Service is likely to be met if one or a number of the following characteristics are met:

- the perceptions of the adult(s) concerned and whether they perceive the impact of harm as serious;
- it has a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected;
- it has a clear and significant impact, or potential impact, on the health and

well-being of others;

- it involves serious or repeated acts of omission or neglect that compromise an adult's safety or well-being;
- it constitutes a potential criminal offence against the adult at risk;
- the action appears to have been committed with the deliberate and harmful intent of the perpetrator(s);
- it involves an abuse of trust by individuals in a position of power or authority; and
- it has previously been referred to a regulated service provider for action, and has not been sufficiently addressed.

If there is doubt about whether the threshold for Adult Protection has been reached, the concern should be discussed with the HSC Trust Adult Protection Gateway Service and a DAPO will advise whether the matter meets the threshold for referral into the Adult Protection Gateway Service.

Where a criminal act is either alleged or suspected, a report must be made to the PSNI.

### **10.3. A Determination that the Threshold for Referral to Adult Protection Gateway Service is Not Met – Alternative Safeguarding Responses**

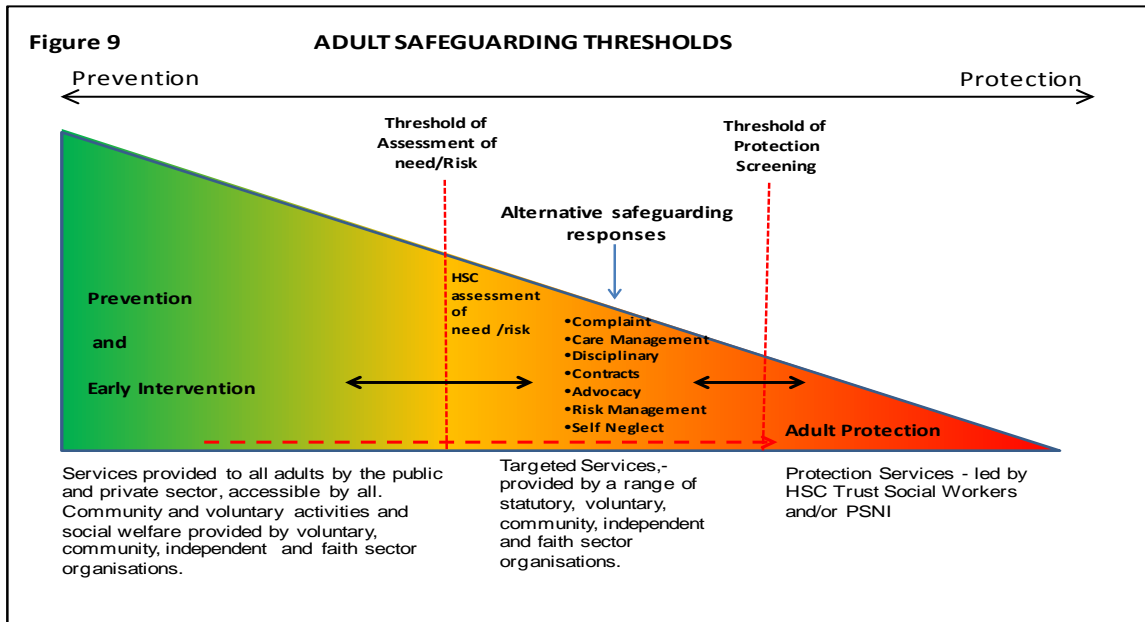
Where it is determined that the threshold for Adult Protection has not been met, other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made. This is a matter for professional judgement, taking account of the individual circumstances and the wishes and views of the adult and may include:

- a) escalation to the service manager to address any issues about the quality of service provision;
- b) referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
- c) referral to a care manager/key worker for re-assessment and review of service user/carer's needs, views and care plan, or where appropriate a mental capacity assessment;
- d) action taken under complaints procedures;
- e) action taken under human resources/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
- f) referral to an advocacy service;
- g) referral to another service;
- h) a risk management intervention in relation to self neglect;
- i) a strategy to manage risks within a complex group living environment and the management of challenging behaviour;
- j) no further action required;

or a combination of two or more of the above.

Where an HSC Trust Adult Protection Gateway Service has agreed an alternative course of action, there must be mechanisms in place to ensure that those given lead responsibility to take certain actions report back to the DAPO on the outcome of the actions taken. All organisations involved in contributing to alternative courses of action will be expected to cooperate fully with HSC Trusts.

Figure 9 below shows where the thresholds sit in relation to the continuum of safeguarding activity.

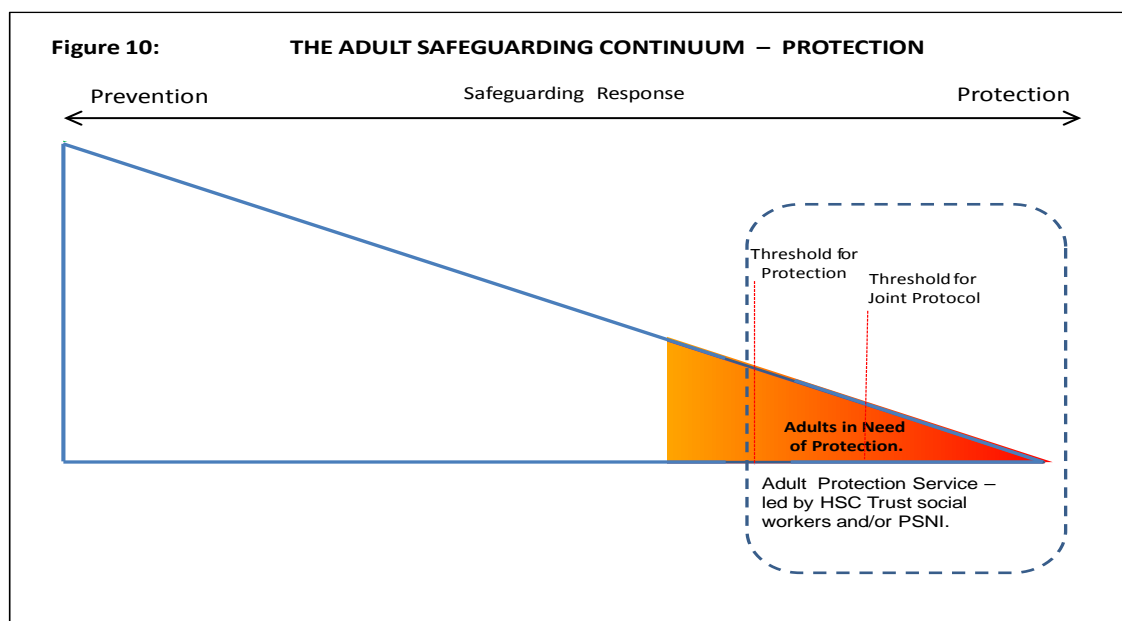


Any safeguarding concerns relating to breaches of regulations or non-compliance with care or service standards are matters for the regulator, regardless of whether the threshold of serious harm has been reached. The HSC Trust should raise such concerns with the RQIA and will then co-ordinate an interagency response. The role of RQIA in inspection and regulation is outlined in section 9 and will be critical in the identification and prevention of safeguarding concerns or incidents in a proportionate manner to prevent unnecessary engagement of the Adult Protection Gateway Service.



## 11. ADULT PROTECTION SERVICES

Figure 10 shows the Adult Protection Service on the safeguarding continuum.



HSC Trusts and the PSNI are the lead agencies with responsibility for adult protection.

Each **HSC Trust** will have an Adult Protection Gateway Service which will receive adult protection referrals. Referrals outside normal working hours should be made to the Regional Emergency Social Work Service (RESWS). Referrals will be accepted from any source, irrespective of Programme of Care boundaries.

**HSC Trusts** will be the lead agency in terms of the co-ordination of joint Adult Protection responses. Within each HSC Trust, responsibility for the Adult Protection rests with the Executive Director of Social Work, and the lead profession within HSC Trusts is social work.

In circumstances where a crime is alleged or suspected, a referral to the **PSNI** should be made by telephoning 101, or in an emergency, 999. Both numbers are accessible on a 24 hour, 7 days per week basis. The PSNI will be the lead criminal investigative agency and will progress a criminal investigation where required.

The **PSNI** will be the lead criminal investigation agency and a report should be made to the PSNI where a crime is alleged or suspected. Within PSNI, responsibility for Adult Protection rests with the Chief Superintendent who has responsibility for the Public Protection Branch<sup>17</sup>.

A Joint Protocol will guide interagency referral, consultation and information exchange and working arrangements and will provide clarity in respect of the roles of

<sup>17</sup> Responsibility for Adult Safeguarding within PSNI is subject to organisational change. Changes will be reflected within the policy once completed.

the PSNI and HSC Trusts in the delivery of the adult protection response. The Joint Protocol will outline when and how other agencies will be engaged for the purpose of an adult protection investigation and protection planning.

Regional adult protection procedures for HSC Trusts will be developed by the HSCB, endorsed by the NIASP and LASPs and implemented across the region to ensure that adult protection responses and practice are consistent across all HSC Trust areas. HSC Trusts will be responsible for implementing these procedures on behalf of the HSCB.

PSNI is guided by current the Association of Chief Police Officers (ACPO) guidance 'Safeguarding and Investigating the Abuse of Vulnerable Adults 2012' as well as established protocols such as Safeguarding Vulnerable Adults (Regional Adult Protection Policy and Procedural Guidance) 2006 and 'Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' NIASP 2009. The Public Protection Branch (PPB) will be responsible for triaging reports under Joint Protocol arrangements. When a PPB passes the adult protection response to another branch of PSNI, the PPB will retain oversight and ensure ongoing engagement and communication with other partners under Joint Protocol.

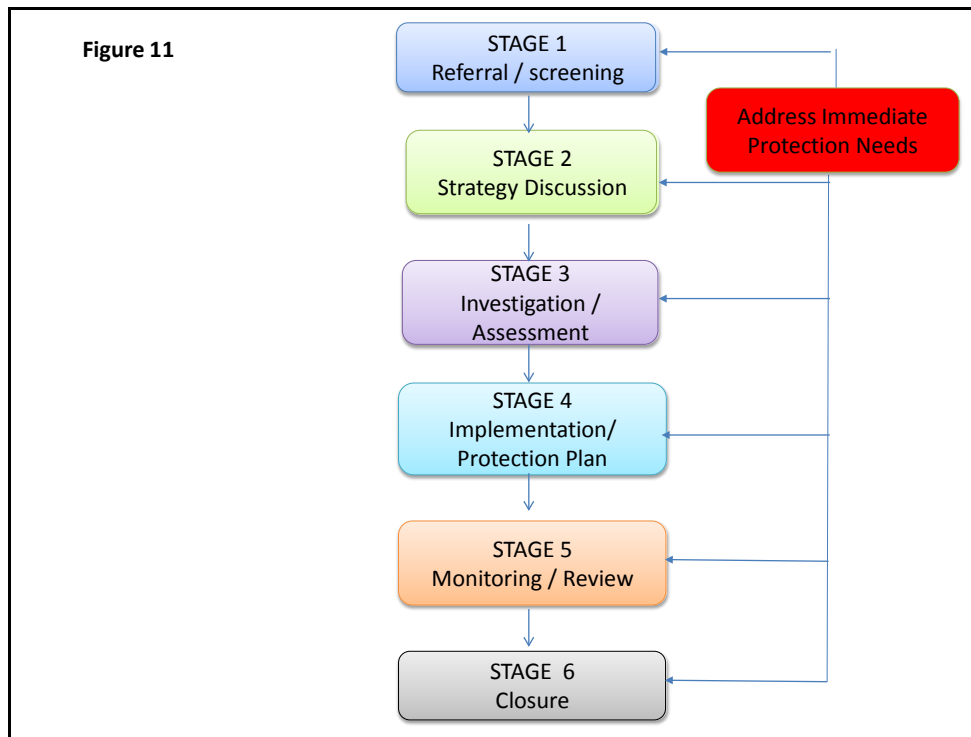
All operational adult safeguarding policies, procedures and protocols in support of this policy must be consistent with the underpinning principles contained in section 5 of this policy.

### **11.1. Adult Protection Process**

Each adult protection intervention is likely to be unique and the response made must allow for flexibility and individualised decision-making. It is important that each adult protection intervention is conducted without undue delay, remains outcome focused, rather than process driven, and is subject to ongoing monitoring and review at an appropriately senior level. At all stages throughout the adult protection intervention, consideration should be given to whether the threshold for the Adult Protection Gateway Service continues to be met. Any action necessary to address immediate protection needs of the adult must be taken regardless of which stage of the process has been reached.

Each intervention will be made in accordance with an agreed process. A typical protection process is contained in figure 11 below encompassing 6 distinct stages. While presented in stages, the process is not intended to be linear in nature. It is possible that some stages will run in parallel and it may also require moving between stages in both directions. This policy does not advocate specific timescales for progressing through the stages of the protection process, because it is important that flexibility is maintained to allow for professional decision making. There can be complex issues to be managed such as fluctuating capacity to make decisions and complex investigations that may require interagency collaboration and consultation including cooperation with any PSNI investigations. Nonetheless, it is important that all adult protection interventions are progressed in a timely manner, and must not be allowed to drift unnecessarily.

Figure 11 shows the six stages of the Adult Protection Process.



At every stage the adult's human rights must be considered, and evidence of this recorded. The adult's rights, needs, views and wishes, should be central to the protection intervention to ensure that they receive the support needed to achieve an agreed outcome.

Processes and procedures in themselves will not protect, people and good practice will.

A **Designated Adult Protection Officer (DAPO)** will be responsible for the management of each referral received by a HSC Trust. DAPOs will be in place both within the Adult Protection Gateway Service, and within core services teams. Following initial screening by the Adult Protection Gateway Service, a DAPO in core services may be asked to manage the referral going forward.

Every DAPO must:

- be social work qualified;
- be working in a minimum of a band seven;
- have first line management responsibilities, or in a senior practitioner role;
- be suitably experienced; and
- have undertaken the necessary training (see section 15).

The role of the DAPO is to:

- make sure the needs, safety and wishes of the adult at risk are kept central to any actions and decisions taken;
- screen the referral;
- make contact with PSNI if a crime is alleged or suspected, or there is an

- immediate risk of harm to an adult at risk;
- make key decisions including whether the threshold for protection intervention has been met;
- manage and coordinate the adult protection intervention;
- ensure that any risks to the adult(s) and others potentially at risk are assessed and agreed actions taken;
- analyse needs and risk assessments to determine the most appropriate course of action;
- inform and involve other agencies as necessary, and work with them to plan and carry out actions taken;
- be responsible for coordinating the sharing of information between agencies;
- ensure the support needs of the adult at risk and others affected are considered throughout;
- ensure appropriate documentation and records are fully completed, including records of all decisions taken;
- make sure the adult at risk and the referrer are given regular feedback, insofar as this is possible;
- analyse the adult safeguarding data within their service area and contribute to the governance arrangements as appropriate; and
- ensure that the connections are made with related interagency mechanisms such as:
  - Multi Agency Risk Assessment Conference (MARAC)
  - Domestic and sexual violence services
  - Public Protection Arrangements in Northern Ireland framework (PPANI)
  - Human trafficking procedures
  - Hate Crime Practical Action Scheme
  - The Office of Care and Protection (or equivalent)
  - Child Protection Gateway Service
  - Business Services Organisation Counter-Fraud Unit.

The DAPO may decide to close the adult protection process at any stage if:

- it is agreed that further investigation, assessment or intervention is not required to protect the adult at risk;
- the DAPO decides that an alternative safeguarding response is more appropriate, proportionate and effective to address the concern identified;
- a Protection Plan has been agreed and is in place and is effectively addressing the needs of and the risks to the adult; or
- the adult chooses to withdraw from the protection process.

Where the safeguarding concern relates to the quality of care provided to an adult in receipt of a regulated HSC service, the DAPO will engage the RQIA to ascertain whether the provider is in breach of regulation or minimum standards. The RQIA will act on all safeguarding concerns where there are breaches of standards or regulation and, where necessary, use their powers of improvement or sanction to ensure that the provider addresses any breach of the minimum standards to the satisfaction of RQIA.

The PSNI will be the lead agency when a criminal investigation is required, and any other related investigations or assessments must be coordinated with the PSNI.

Responsibility for coordinating, and communicating the outcome of, the criminal investigation lies with the Detective Inspector PPB. A criminal investigation will take precedence over any other adult safeguarding process. For example, a disciplinary process should not commence until after the conclusion of an adult protection criminal investigation by the PSNI, or following approval by PSNI.

## **11.2. Large Scale and/or Complex Investigations**

A large-scale adult protection investigation may be initiated when a number of adults at risk have allegedly been abused or patterns or trends are emerging which suggest serious concerns about the quality of care, which put the safety of service users at risk.

This could include any of the following:

- multiple concerns within one service provider;
- one person is suspected of causing harm to multiple adults and/or in a number of settings;
- a group of individuals are alleged to be causing harm to one or more adults;
- where care arrangements are complicated by cross-boundary considerations.

A large-scale adult protection investigation is likely to involve a range of organisations, and potentially a number of individual adult protection interventions.

Complex (i.e. organised or multiple) abuse is defined as abuse involving one or more abusers and a number of related or non-related adults at risk. The abuser concerned may be acting with others to abuse adults at risk, may be acting in isolation, or may be using an institutional framework or position of authority to access adults at risk for abuse.

Such abuse can occur both as part of a network of abuse across a family or community and within institutions such as residential or nursing homes, supported living facilities, day support settings and in other provisions such as voluntary groups. There may also be cases of adults at risk being abused through the use of the internet. Such abuse is profoundly traumatic for the adults at risk who are involved. The investigation of large scale and/or complex abuse requires specialist skills from PSNI and HSC Trust staff.

Every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) involved. Some investigations become extremely complex because of the number of people or places involved and the timescale over which the abuse is alleged to have occurred.

On receipt of information which may indicate organised or multiple abuses, the HSC Trust Designated Officer should immediately consider whether a report to the PSNI is appropriate, initiate a joint strategy meeting and, where necessary, establish a Strategy Management Group (SMG) to oversee the process of investigation. Core representatives of SMG are:

- PSNI;
- HSC Trust nominated DAPO;
- a senior manager from the relevant adult programme of care; and

- RQIA (where the allegation relates to a regulated service).

Appropriate legal advice will be necessary and should be sought through PSNI and HSC Trust legal advisers.

The SMG will:

- establish the principles and practice of the investigation, draw up an investigation plan and ensure regular review of progress against that plan;
- establish and manage an Investigative Team within their respective agencies;
- ensure co-ordination between the key agencies and Investigative Team
- address the issue of resourcing individual investigations;
- act in a consultative capacity to those professionals who are involved in the investigation;
- draw up a media strategy that will address who will take responsibility for responding to the media;
- agree communication strategy/liaison with victims/families and carers involved in the investigation;
- agree level of information sharing, where appropriate to do so, with the proprietor and the staff of the facility/service under investigation;
- at the conclusion of the investigation, discuss salient features of the investigation with a view to making recommendations for improvements either in policy or in practice.

### **11.3. Operational Protection Policies and Procedures**

The HSCB's regional operational adult protection procedures will underpin this policy and provide guidance to support good practice and sound professional decision making. Procedures will be subject to regular review.

Operational policies and procedures should:

- a) clarify roles, responsibilities and expectations at all levels;
- b) outline the importance of, and interface with, the Joint Protocol;
- c) provide procedures for inter-agency working across the full range of organisations;
- d) provide a consistent framework to guide adult protection interventions;
- e) promote flexibility and a focus on outcome;
- f) describe how the threshold of serious harm is applied at each stage of the process to enable the most proportionate response to be identified;
- g) provide guidance on the management of adult protection referrals where more than one HSC Trust is involved;
- h) encourage reflective professional practice;
- i) support robust decision making;
- j) strengthen professional line management and governance arrangements;
- k) outline procedures for integration with the other investigations (see the role of the DAPO earlier in this section);
- l) define information exchange procedures;
- m) outline record keeping requirements; and
- n) describe how large scale and/or complex investigations should be conducted.

## **12. CONSENT AND CAPACITY**

### **12.1. Consent**

Consideration of consent is central to adult safeguarding. Consent is a clear indication of a willingness to participate in an activity or to accept a service, including a protection service. It may be signalled verbally, by gesture, by willing participation or in writing. No one can give, or withhold, consent on behalf of another adult unless special legal provision for particular purposes has been made for this.

For consent to be valid, it must be given voluntarily by an appropriately informed person who is able to consent to the intervention being proposed. In cases where the individual lacks capacity, decisions will usually be made on behalf of the individual in accordance with current legal provisions.

A consent-driven approach to adult safeguarding will always involve:

- a presumption that the adult at the centre of a safeguarding decision or action is able to give or withhold consent unless it is established otherwise;
- acknowledging that an adult who lacks capacity to make a decision cannot give consent but that he or she should still be involved in decision-making as far as possible and given appropriate support;
- acknowledging that everyone who has capacity to make a certain decision has the right to pursue a course of action that others may judge to be unwise, but that sometimes a balance must be struck between an individual's human rights and the need to intervene to protect others;
- providing support to an adult where they have withheld consent and this has been overridden;
- ensuring consent/non-consent is informed through the provision of full and accurate information, making sure that the information is conveyed in a way which the adult fully understands and taking all practicable steps to help the person make and communicate the decision; and
- understanding that the choices and decisions made by the individual at any one time are not seen as irrevocable or non-negotiable.

Where there is a concern that an adult may be at risk of, or experiencing, harm and there are concerns about coercion or undue influence, this should be referred to the HSC Trust in accordance with section 11.

### **12.2. Capacity**

An adult will always be assumed to have capacity to make a decision unless it is suspected otherwise. Capacity can fluctuate, and is both issue and time specific, therefore should be kept under regular review in connection with any safeguarding intervention, in particular a protection intervention.

Where there is a reasonable doubt regarding the capacity of an adult to make a specific decision or series of decisions, a referral must be made to the HSC Trust. The organisation or individual making the referral may need to consider any reasonable and proportionate interim steps necessary to protect the adult pending

further enquiries by the HSC Trust. An HSC professional within the HSC Trust will conduct a capacity assessment in accordance with existing legislation and guidance.

### **Lack of capacity**

Tensions between an adult's autonomy and the need to intervene to keep an adult safe makes deciding whether or not to intervene when an adult lacks capacity to make a decision particularly difficult, and one that must always requires professional judgement in respect of the individual circumstances of the adult.

Where an adult lacks capacity to make a certain decision, they should be supported so they can be involved to the fullest extent in the decision that affects their life. Any interventions and actions taken by the HSC Trust must be in the best interests of the person being safeguarded, and in accordance with existing legislation and policy. HSC Trusts should, where appropriate, consult relevant family members or carers when considering action to be taken regarding an adult who lacks capacity to make a decision.

### **12.3. Lack of Consent**

In some circumstances it may be necessary for the withholding of consent to be overridden. Where consent to intervene is not provided by the adult at risk, action to progress a case may still be taken in circumstances where there is a strong overriding public interest, or where a crime is alleged or suspected. This may happen when:

- the person causing the harm is a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service; or
- consent has been provided under undue influence, coercion or duress;
- other people are at risk from the person causing harm; or
- a crime is alleged or suspected.

In these circumstances, the adult should be informed of that decision, the reason for the decision, and reassured that as far as possible no actions will be taken which affect them personally without their involvement. Consideration should be given to any support the adult may need at this time, as they may be distressed by the prospect of their information being shared without their consent.

### **12.4. Advocacy**

Advocacy involves enabling people to say what they want, to have their views heard, and empowering them to speak up for themselves. It informs the person about their options and helps them to take action when necessary to have their voice heard and secure their rights.

Whilst advocacy is a social work role, the use of independent advocacy services to support the adult at risk in making their choices may be appropriate, particularly for those who have difficulty being heard or expressing their views, or where there are conflicting interests. This is particularly the case where HSC staff, professionals or family are of the opinion that what the person wants is not in their best interests.



Advocacy can assist adults to be involved in, and influence, decisions taken about their care. It helps to ensure that the adult at risk remains central to the decision making process. Advocacy should not make decisions on behalf of the adult at risk, but always work in partnership with the adult they are supporting. People who are lack capacity to make a decision rely more heavily on others for many aspects of their care, treatment and support, and have the potential to benefit more from advocacy services to assist them exercise their rights.

### 13. ACCESS TO JUSTICE: SUPPORT FOR VICTIMS

Where a crime is alleged to have occurred there is a duty on PSNI to investigate. There are also a range of mechanisms in place to support a victim when giving a statement to the PSNI, evidence at court and in terms of emotional and practical support services more generally. The provision of these services requires effective cooperation across a range of organisations including the PSNI, HSC Trusts, the Public Prosecution Service and voluntary sector service and support providers.

Where a crime is reported to the PSNI a victim of crime information leaflet is available which provides contact details of general support services such as Victim Support NI and NSPCC Young Witness Service, as well as specialist support services, including for families bereaved through murder or manslaughter, victims of domestic and sexual violence, victims of trafficking and young victims of crime among others. The PSNI can refer victims of crime to Victim Support NI, where referral to specialist support services is also available dependent on the needs of the individual. Where an individual has concerns about their safety they should refer this to the police.

Victims of crime can have access to additional support to help them give evidence, as part of criminal proceedings where a person is under the age of 18, or where the quality of the evidence is likely to be affected because the person has mental health issues, learning or communication difficulties, a neurological disorder or a physical disability. Additional support is also available to those victims who are intimidated and the quality of whose evidence is likely to be affected because of fear or distress about testifying, for example, where the person is a victim of domestic violence, hate crime, trafficking, exploitation, bullying or abuse by professionals or carers or family members.

For these types of victims the PSNI will carry out interviews in accordance with 'Achieving Best Evidence in Criminal Proceedings' guidance. This sets out good practice in interviewing victims and witnesses and in preparing them to give their best possible evidence in court, so that they have an opportunity to access justice and provide their best evidence. Such interviews are normally video recorded.

Victims will have their needs assessed by the PSNI or Victim and Witness Care Unit (which provides a single point of contact from the point when the case file is transferred from the PSNI to the Public Prosecution Service).

Additional support at court, such as special measures<sup>18</sup>, may be applied for by the Public Prosecution Service, with final decisions taken by the judge on their availability. More than one special measure may be granted in a particular case, with this again a decision for the judge. The special measures, as set out below, include:

- screens/curtains in the courtroom so the victim does not have to see the defendant;

<sup>18</sup> A leaflet on special measures is available at [http://www.psni.police.uk/special\\_measures\\_leaflet.pdf](http://www.psni.police.uk/special_measures_leaflet.pdf)  
The legislation governing special measures can be found at:  
<http://www.legislation.gov.uk/nisi/1999/2789/contents>

- a live video link allowing evidence to be given away from the courtroom, which also allows for a support to be present with the witness in the live link room;
- giving evidence in private, where the case involves a sexual offence, a slavery or human trafficking offence, or the person is deemed to be intimidated;
- video recorded statements – these allow the main evidence to be given using a pre-recorded video statement;
- using communication aids, such as alphabet boards (where the person's evidence is likely to be affected due to a learning or communication difficulty, mental health issue, physical disability etc.); and
- removal of wigs or gowns.

Another special measure is assistance from a communication specialist (a Registered Intermediary) when a person is telling the police what happened to them or is giving evidence in court. Registered Intermediaries are professionals with specialist skills in communication. The role of Registered Intermediaries is to facilitate the giving of evidence rather than provide a general support role. They assist a vulnerable person, who has a significant communication difficulty, during the criminal justice process if their communication difficulties would diminish the quality of their evidence. The Registered Intermediaries Schemes pilot is helping vulnerable people have access to justice where it may not have been possible before.

As well as help when giving evidence victims also have access to a range of general support services. Victim Support NI<sup>19</sup> helps people who have been a victim of, or a witness to, a crime. They provide emotional support, information and practical help to victims, witnesses and others affected by crime through compensation, community and witness services. Victim Support NI can also refer victims to specialist support services, where appropriate and available.

A Victim Charter provides victims of crime with relevant information, sets out what their entitlements are and the standards of service that they can expect to receive as they move through the criminal justice process. It will also make clear to service providers exactly what their duties are in ensuring victims receive the right level of service. The Charter provides information on the support services that are available to victims of crime, including specialist services.

<sup>19</sup> Further information on Victim Support NI can be found at: [www.victimsupportni.co.uk/](http://www.victimsupportni.co.uk/)

## 14. INFORMATION MANAGEMENT AND INFORMATION SHARING

### 14.1. Information and Record Management

Information associated with adult safeguarding is likely to be of a personal and sensitive nature and its use is governed by the common law duty of confidentiality. At all times 'personal data' and 'sensitive personal data'<sup>20</sup> must be managed in accordance with the law, primarily the Data Protection Act 1998 (DPA) and the Human Rights Act 1998 which, among other things, gives individuals the right to respect for private and family life, home and correspondence.

The eight principles of the DPA state that personal data must be:

- processed fairly and lawfully and only for purposes compatible with the reason(s) for which the information was originally obtained;
- adequate, relevant and not excessive for the purposes for which it is processed;
- accurate and kept up to date;
- not kept for longer than is necessary;
- processed in line with the rights of the data subject;
- held securely; and
- not transferred to other countries outside the EEA without adequate protection.

All organisations providing targeted services to adults at risk must have an information management policy and associated governance arrangements in place which complies with the DPA and the Human Rights Act 1998. These policies must include the procedures to be followed by staff and volunteers in relation to:

- information management, including recording of information, its secure storage, and how this can be accessed and by whom;
- sharing information outside of the organisation for safeguarding purposes, and how requests for information will be considered and assessed (see Information Sharing for Safeguarding Purposes below);
- training to be provided to staff in relation to their duties under the DPA;
- subject access requests;
- complaints about information management; and
- identified breaches of data protection within the organisation.

Good records management standards and practices are required for the organisation to ensure confidentiality and that the security of service user information is respected. Many professionals are governed by a Code of Practice or Code of Conduct issued by the professional body with which they are registered, which will contain guidance on information management to support organisational policies. Guidance for voluntary, community, independent and faith sector organisations on the management of records, confidentiality and sharing of information is available in the Volunteer Now guidance document 'A Shared Responsibility'<sup>21</sup>. 'Good Management

<sup>20</sup> 'Sensitive Personal Data' is defined by Section 2 of the Data Protection Act 1998:  
<http://www.legislation.gov.uk/ukpga/1998/29/section/2>

<sup>21</sup> 'Safeguarding Vulnerable Adults: A Shared Responsibility' can be accessed at:  
<http://www.volunteernow.co.uk/fs/doc/publications/vn-sva-web-full-colour.pdf>

Good Records'<sup>22</sup> provides guidance for those who work within or under contract to Health and Social Care statutory organisations on the required standards of practice in the management of records.

## 14.2. Information Sharing for Safeguarding Purposes

In relation to adult safeguarding, the duty to share information about an individual can be as important as the duty to protect it. Effective safeguarding will depend on information being made available to those who need it at the right time. Proportionate information sharing may be required to prevent harm to the adult at risk or to others, and can facilitate preventative or early intervention approaches.

It is important that confidentiality is not confused with secrecy. Proportionality is the key in respect of the risks associated with deciding whether or not to share information.

Organisations and professionals should not give assurances of absolute confidentiality in adult safeguarding where there are concerns about risk of harm to one or more adults, nor should it be assumed that someone else will pass on information which may be critical to the prevention of harm to an adult.

Information sharing is one form of data processing, and as such is covered by principles and requirements of the DPA. The Information Commission's Office (ICO) has published a statutory Data Sharing Code of Practice<sup>23</sup> to assist organisations to comply with the DPA. The code is applicable to all organisations involved in sharing personal data, whether this is within different branches of the same organisation, or with a third party organisation. It contains guidance in factors to consider when deciding whether or not to share personal data, including checklists to assist organisations in their decision making.

Organisations that collect or hold personal data or sensitive personal data should explain in advance to the data subject how their information will be used, including under what circumstances the information might be shared. Guidance on how this can be undertaken is contained in the Privacy Notices Code of Practice<sup>24</sup> published by the ICO.

Targeted services providers must have procedures for staff and volunteers on how to share information in compliance with the DPA and the ICO Code of Practice. Decisions about what information should be shared and with whom should be taken on a case by case basis, and in accordance with organisational information management policies and the legal framework, and in line with this policy. The management interests of an organisation should not override the need to share information for safeguarding purposes.

<sup>22</sup> 'Good Management Good Records' can be accessed at:

<http://www.dhsspsni.gov.uk/index/gmgr.htm>

<sup>23</sup> The Data Sharing Code of Practice can be accessed at:

[https://ico.org.uk/media/for-organisations/documents/1068/data\\_sharing\\_code\\_of\\_practice.pdf](https://ico.org.uk/media/for-organisations/documents/1068/data_sharing_code_of_practice.pdf)

<sup>24</sup> The 'Privacy Notices Code of Practice' can be accessed at:

[https://ico.org.uk/media/for-organisations/documents/1610/privacy\\_notices\\_cop.pdf](https://ico.org.uk/media/for-organisations/documents/1610/privacy_notices_cop.pdf)

If anyone has concerns about risk of harm to an adult, they should seek advice from the relevant HSC Trust or the PSNI.

Personal data may be shared when:

- the adult has given his or her valid consent (which in the case of sensitive personal data must be explicit); or
- where information sharing is necessary for matters of life or death or for the prevention of serious harm to the individual; or
- where sharing is necessary for the purposes of the administration of justice;
- where sharing information is for public or statutory duties.

Where the decision is made to share information without consent, the organisation must ensure that the adult is clearly informed of what information will be shared, why it will be shared, and who it will be shared with, providing this does not increase the risk to the adult. Organisations should avoid asking for consent to share information when it is likely that a decision will be taken to share the information regardless of whether consent is given. Any sharing of information must meet conditions under Schedules 2 and 3 of the Data Protection Act.

If there is reason to believe that sharing information due to a statutory duty to disclose may increase the risk of harm, or where there is doubt about whether the organisation can or should share information, the organisation may wish to obtain legal advice.

Good record keeping of decision making is essential in cases where information sharing is being considered. Staff should maintain records of the information gathered which explains and justifies their decisions.

### **14.3. Sharing Information Between Agencies**

Effective safeguarding cannot be achieved without organisations working collaboratively to ensure the safety of the adult at risk is prioritised. Working together is dependent on there being a clear framework for doing so, and adult safeguarding should be based on good communication across sector and agency boundaries.

The effective and timely sharing of information between organisations is essential to deliver high quality adult safeguarding services focused on the needs of the adult.

Agencies and organisations which are required to share information on a regular basis to safeguard adults at risk must have Information Sharing Agreements (ISAs) in place which identify key members of staff and contact points within the organisation through which information can be channelled, including out of normal working hours. The agreements should be agreed at Board/Director level and subject to regular review.

Member organisations of NIASP have all signed an information sharing agreement. This agreement will stipulate when information may be shared without the subject's consent.

An ISA should outline how organisations have agreed to share information and ensure compliance with legal requirements. The purpose of an ISA is:

- to facilitate the secure exchange of information in an appropriate format, where necessary, to ensure the health, well-being and safeguarding of adults at risk;
- to provide a framework for the secure and confidential sharing of personal data between the partner organisations;
- to promote consistency of information sharing across partner organisations; and
- to support professional decision making in individual cases.

When an HSC Trust has a contract or commissioning arrangement with a third party organisation, the contract or commissioning agreement must state how the third party organisation must handle any personal data obtained through provision of the service. This must include how the information will be securely stored, managed, disposed of, and where appropriate shared, in compliance with the DPA and the Human Rights Act 1998.

## **15. SAFEGUARDING TRAINING**

Effective adult safeguarding requires a specific level of knowledge, expertise and skill and understanding. Adult safeguarding is complex and must be delivered by a confident, competent and trained workforce, which includes those working in a voluntary or unpaid capacity.

NIASP has a responsibility to develop an inter-agency and inter-disciplinary approach to adult safeguarding training and practice development. NIASP will develop and agree a Regional Adult Safeguarding Training Framework which will specify learning outcomes and core content to meet a range of identified training needs within partner organisations.

The framework will provide a number of levels of training which reflect the varying levels of expertise required and the differing needs of organisations across the safeguarding continuum. The appropriate level of training will be determined by the roles and responsibilities of the individual.

Service providers should use the NIASP framework to identify and set out training and development pathways for their staff and volunteers, to ensure they have the appropriate skills and knowledge to engage in preventative activity and respond to safeguarding concerns commensurate with their role. This may involve a combination of formal training events, and time for staff to reflect on their own practice and the practice of others. Records should be maintained of all training and development undertaken by staff and volunteers.



## 16. A CONTINUOUS LEARNING APPROACH

All practitioners, agencies and organisations involved in work with adults at risk must ensure that the highest possible standards of care, support and protection are provided and maintained at all times, and improvements identified and put in place on a continuous basis. The NIASP will foster a culture of collaborative learning and continuous practice and service improvement in connection with adult safeguarding. This will require knowledge and understanding of the 'system' at the front-line, the identification of and exploration of learning from cases with different outcomes for adults at risk of harm, or adults who have been harmed and the implementation of learning from both. The emphasis should be on learning for the purpose of positive proactive change and improvement. It will require the support of staff who will be responsible for the implementation of change.

The NIASP will promote a culture of continuous improvement and collaborative learning to improve outcomes for adults who may be at risk and their experience of the adult protection responses.

This does not mean that those responsible for harming an adult at risk by an act of commission or omission should not be held to account. A range of accountability mechanisms already exist, including disciplinary mechanisms. These should be used where it is appropriate to do so.

The ultimate aim is to establish a system which promotes continuous learning and improvement to:

- establish whether there are lessons to be learned about the way in which local professionals, agencies and organisations work together to safeguard adults at risk;
- identify clearly what those lessons are, how they will be acted upon, by whom and by when, and what is expected to change as a results;
- improve multi-disciplinary and interagency working, and promote better approaches to prevention, protection and support of adults at risk.

The NIASP will seek the full support, cooperation and participation of its member organisations to identify opportunities for learning and to bring these to the attention of the NIASP.

**APPENDIX 1****This policy is of specific relevance to:**

- all NI Government Departments, their agencies and arm's length bodies;
- local councils;
- the Health and Social Care Board and Health and Social Care Trusts;
- Business Services Organisation;
- The Northern Ireland Ambulance Service HSC Trust;
- The Public Health Agency;
- The Northern Ireland Adult Safeguarding Partnership and the five Local Adult Safeguarding Partnerships;
- The Police Service of Northern Ireland;
- The Public Prosecution Service;
- The Probation Board for Northern Ireland;
- Policing and Community Safety Partnerships;
- The Northern Ireland Prison Service;
- The Northern Ireland Housing Executive;
- The Social Security Agency;
- regulatory and Inspection bodies across all sectors, including: Criminal Justice Inspection Northern Ireland, the Regulation and Quality Improvement Authority, The Education and Training Inspectorate, the General Teaching Council for Northern Ireland, the Northern Ireland Social Care Council, the General Medical Council, the Nursing and Midwifery Council and the Charities Commission;
- schools;
- Domestic and Sexual Violence Partnerships;
- voluntary and community organisations who work with, provide services to, or engage in, activities with adults;
- voluntary and community organisation umbrella bodies;
- Faith organisations and communities;
- care staff agencies;
- organisations and individuals who provide personal care funded through direct payments or through an individual's own funds;
- carers;
- Carers NI and other advocacy groups representing carers;
- housing associations;
- supported housing providers, the Northern Ireland Federation of Housing Associations Private landlords;
- accommodation providers;
- financial institutions, including: banks, Post Offices and building societies;
- credit unions;
- professions, including solicitors and barristers;
- The Office of Care and Protection;
- Northern Ireland Courts and Tribunal Service;
- independent Providers of health and social care service, including: General Medical Practitioners, pharmacists, dentists, private hospitals, private sector providers of domiciliary care, residential and nursing care homes, independent counsellors and independent therapist services;
- Allied Health Professionals and their regulatory bodies;

- opticians;
- further and higher education institutions;
- advice groups and helplines; for example, disability groups such as Disability Action and Action for Hearing Loss;
- Self help, user and advocacy groups;
- leisure facilities; and
- members of the public.

## APPENDIX 2

## Glossary

Access NI	AccessNI is a criminal history disclosure service in Northern Ireland. By law some employers must check your criminal history before they recruit. When asked by these employers, AccessNI supplies criminal history information about job applicants, volunteers and employees.
Adult Protection Gateway Service	The <b>Adult Protection Gateway Service</b> is the central referral point within the HSC Trust for all concerns about an adult who is, or may be, at risk.
Care Plan	A care plan sets out the assessed care and support needs of an individual and how those needs will be met to best achieve the individual's desired outcome. The individual should be fully involved in the development of the care plan.
Care Management	Care Management embraces the key functions of: case finding; case screening; undertaking proportionate, person-centred assessment of individual's needs; determining eligibility for service(s); developing a care plan and implementing a care package; monitoring and reassessing need and adjusting the care package as required.
Child Protection Gateway Service	The <b>Child Protection Gateway Service</b> is the central referral point within the HSC Trust for all concerns regarding the safety and welfare of children.
CJINI	Criminal Justice Inspection Northern Ireland is the independent statutory inspectorate with responsibility for inspecting all aspects of the criminal justice system in Northern Ireland apart from the judiciary. It also inspects a number of other agencies and organisations that link into the criminal justice system. CJI is funded by the Department of Justice and the Chief Inspector reports to the Minister for Justice.
Delegated Statutory Functions	Delegated Statutory Functions refer to all requirements of legislation with which statutory HSC organisations must comply. In successive legislation, the Health and Social Care Board (HSCB) is designated as 'The Authority' that is required to fulfill all relevant statutes. The HSCB delegates this responsibility to HSC Trusts under legally binding schemes referred to as 'Schemes for the Delegation of Statutory Functions'.
Designated Adult Protection Officer	A social worker within the HSC Trust with responsibility for managing and co-ordinating the adult protection process. The DAPO must: <ul style="list-style-type: none"> <li>• be social work qualified;</li> <li>• be working in a minimum of a band seven;</li> <li>• have first line management responsibilities, or in a senior practitioner role;</li> </ul>

	<ul style="list-style-type: none"> <li>• be suitably experienced; and</li> <li>• have undertaken the necessary training.</li> </ul>
DHSSPS	The Department of Health, Social Services and Public Safety.
DOJ	The Department of Justice.
Direct Payments	Direct payments are paid by an HSC Trust to people who have been assessed by an HSC Trust to meet the eligibility criteria for assistance from social services. A payment is made in lieu of the service so that the person can arrange and pay for their own care and support services instead of receiving them directly from the HSC Trust.
ETI	The Education and Training Inspectorate. The organisation which provides inspection services and information about the quality of education being offered including that within schools, further education and work-based learning, where adults at risk may be enrolled.
HSCB	The Health and Social Care Board. This is the body responsible for arranging or 'commissioning' a comprehensive range of modern, effective and safe health and social services for the people of Northern Ireland.
HSC Trust	Health and Social Care Trust. There are five Health and Social Care Trusts in Northern Ireland, providing local and regional health and social care services to the Northern Ireland public. The use of "HSC Trust" in the Policy document refers to the following five HSC Trusts: <ul style="list-style-type: none"> <li>• The Belfast Trust</li> <li>• The South Eastern Trust</li> <li>• The Southern Trust</li> <li>• The Northern Trust</li> <li>• The Western Trust.</li> </ul>
Joint Protocol	The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009. The Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.
LASP	Local Adult Safeguarding Partnerships. The five local multi-agency, multi-disciplinary partnerships located within their respective HSC Trusts.
MARAC	A MARAC is a Multi-Agency Risk Assessment Conference. It is a forum for local agencies to meet with the aim of sharing information about the highest risk

	cases of domestic violence and abuse and to agree a safety plan around victims.
National Referral Mechanism	A framework which exists to assist in the formal identification of victims of human trafficking and help to coordinate support to potential victims to appropriate service. The Department of Justice (DOJ) funds organisations to provide this support to adult potential victims of human trafficking. The PSNI are the lead agency in managing this response. However, consideration should be given to use of the Joint Protocol arrangements.
NIASP	The Northern Ireland Adult Safeguarding Partnership. The regional multi-agency, multi-disciplinary partnership that brings together representatives from organisations and communities of interest who have a significant contribution to make to adult safeguarding.
Office of Care and Protection	Office of Care and Protection is the department of the Court with responsibility for the administrative work associated with Part VIII of the Mental Health Order. This includes matters relating to enduring or lasting powers of attorney, and court-appointed deputies.
PBNI	Probation Board for Northern Ireland. PBNI works alongside statutory and other partners to minimise the risk of harm posed by offenders. PBNI is a Non Departmental Public Body of the Department of Justice (DOJ).
PCSP	Police and Community Safety Partnerships. Local bodies made up of Councillors and independent people in each Council area. PCSPs work with their community to identify issues of concern in the local area and potential solutions, and prepare plans to address these concerns.
Personal data	<p>Personal data means data which relate to a living individual who can be identified –</p> <p>(a) from those data, or</p> <p>(b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller, and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual.</p> <p>It is important to note that, where the ability to identify an individual depends partly on the data held and partly on other information (not necessarily data), the data held will still be “personal data”.</p> <p>The definition also specifically includes opinions about the individual, or what is intended for them.</p>
PPANI	Public Protection Arrangements Northern Ireland. The

	purpose of the PPANI framework is to reduce the risks posed by sexual and violent offenders when they are released into the community in order to protect the public, including previous victims, from serious harm.
PPT	Public Protection Team. These are located in police stations throughout Northern Ireland.
Programme of Care	The structure in HSC Trusts within which social care is commissioned and delivered in Northern Ireland.
Protection Plan	A plan agreed with the adult at risk (or the person representing them or their best interests) detailing the actions to be taken, with timescales and responsibilities, to support and protect the person from harm.
PSNI	The Police Service of Northern Ireland.
RQIA	The Regulatory and Quality Improvement Authority. Northern Ireland's independent health and social care regulator, responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.
Sensitive Personal Data	<p>Sensitive Personal Data means personal data consisting of information as to—</p> <ul style="list-style-type: none"> <li>(a) the racial or ethnic origin of the data subject,</li> <li>(b) his political opinions,</li> <li>(c) his religious beliefs or other beliefs of a similar nature,</li> <li>(d) whether he is a member of a trade union (within the meaning of the M1Trade Union and Labour Relations (Consolidation) Act 1992),</li> <li>(e) his physical or mental health or condition,</li> <li>(f) his sexual life,</li> <li>(g) the commission or alleged commission by him of any offence, or</li> <li>(h) any proceedings for a ny of fence c ommitted or alleged t o ha ve been c ommitted by hi m, the disposal of such proceedings or the sentence of any court in such proceedings.</li> </ul> <p>Sensitive P ersonal D ata has a hi gher t hreshold w hen considering whether or not it can be shared, and carries higher requirements for secure management.</p>

**APPENDIX 3****Bibliography**

The list below contains a list of sources used during the development of this policy. There may have been other documents which were reviewed during the course of the policy development which have been omitted, and where these are identified these will be included in future updates of this document.

<b>Document Title</b>	<b>Author</b>
Adult Support and Protection: Ensuring Rights and Preventing Harm	Edinburgh, Lothian and Borders Executive Group
Evidence Review – Adult Safeguarding	Institute of Public Care
Haringey Safeguarding Adults Multi Agency Information Sharing Protocol	Haringey Council
Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse.	Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board
Protecting our Older People in Northern Ireland: A Call for Adult Safeguarding Legislation	Commissioner for Older People for Northern Ireland
Safeguarding Adults: a National Framework of Standards for good practice and outcomes in adults protection work	The Association of Directors of Social Services
Safeguarding Vulnerable Adults Regional Adult Protection Policy and Procedural Guidance	Health and Social Care Board
Safeguarding Vulnerable Adults A Shared Responsibility	Volunteer Now



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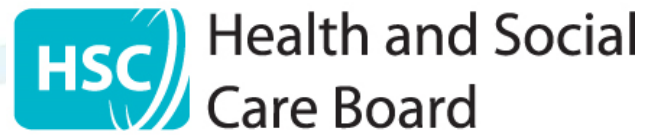
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# **Regional Guidelines for the Management of Patient's Absent without Leave (AWOL) from Adult Mental Health/Learning Disability Inpatient Settings August 2015**

*Improving your health and wellbeing*

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This guidance has been developed in a collaborative manner through engagement and input from relevant stakeholders.

Contributors include:

- The five HSC Trust Mental Health Directorates;
- The Mental Health Service Users Groups within the five HSC Trusts;
- The Bamford Monitoring Group (this group is made up of Service Users, Carers and Patient Client and Council staff);
- PSNI;
- The Department of Justice;
- RQIA and;
- RCN.

An Equality and Human Rights Screening Assessment has been completed and the document updated on the basis of feedback received.

Full consideration has been given regarding the requirements of the Human Rights Act 1998 and the potential for 'unjustifiable breaches'.

This document will be read in conjunction with the following Trust Policies as applicable to individual Trusts:

- Adverse Incident Policy;
- Promoting Quality Care Risk Assessment (PQC) (2010);
- Therapeutic Engagement and Observation Policy;
- Mental Health Order NI (1986);
- Adult Mental Health (Northern Ireland) Order 1986 Code of Practice
- Safeguarding Vulnerable Adult Policy;
- NMC code of professional conduct;
- Complaints policy;
- Restrictive Practices, DOLS Guidance;
- Conducting a Search of Patients and/or their Belongings; and;
- Safeguarding Children Policy.

(This list is not exhaustive)

All Trusts will review existing Policies in light of these guidelines and update them as appropriate.

## **1.0 INTRODUCTION**

All HSC Trusts have a duty to ensure the safety and welfare of service users under their care. Appropriate assessment, therapeutic interventions, observation and supervision is paramount to this care. Despite these interventions, service users do sometimes go absent or abscond from inpatient settings without the agreement or knowledge of staff.

The majority of patients who abscond come to no harm; however, the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness in Northern Ireland (2011), found that between the years 2000 and 2008 twenty eight inpatient suicides in Northern Ireland occurred off the ward. In thirteen of these incidents the patient had left the facility without staff agreement or knowledge; that is they were 'absent without leave' (AWOL).

In addition to the risk of suicide, the use of alcohol and/or drugs which may occur during the incident, as well as missed treatment increase risk associated with absconding from an inpatient setting.

In light of this knowledge it is essential that staff have clear guidance on the action to take in the event of a patient going AWOL to ensure the risks to the patient and/or others is minimised.

## **1.1 PURPOSE OF GUIDELINES**

The overarching purpose of these guidelines is to promote the safety and protection of service users and others in the event of a service user going missing or AWOL.

The guidelines provide a framework for all staff when it is determined that a service user is AWOL.

Whilst this document sets out guidelines to be followed once a patient is identified as AWOL, good practice begins from the first point of contact with the patient on admission.

On admission, risk assessments and safety management plans should always include consideration of the risk of AWOL and associated factors that could affect the health and safety of the patient and/or others in the event of the patient being absent without leave/missing. Trusts should use an evidence based intervention tool to identify risk and inform practice regarding effective therapeutic management of those patients who may be at risk of going absent without leave, for example the East London and City Mental Health NHS Trust 'Anti-Absconding Work Book'.

All patients/family/carers should be advised on admission of the policy in relation to leaving the ward and the need to inform staff if the patient does wish to leave.

## **1.2 THE AIM OF THIS GUIDANCE IS TO:-**

1. Support staff in identifying when a patient should be regarded as Absent Without Leave (AWOL);
2. Minimise the risks to patients and/or others including the risk of disruption to their treatment and care plan;
3. Support staff in identifying the need for Police (PSNI) involvement in a timely and appropriate fashion;
4. Establish a formal and robust reporting and monitoring procedure for AWOL's across the HSC; and;
5. Ensure lessons learnt are appropriately communicated to inform practice.

## **1.3 LEGAL CONTEXT**

The circumstances by which a patient may be missing from hospital without first discussing their absence with staff may be varied.



A voluntary patient may lawfully leave hospital at any time he or she wishes and there is no legal duty upon him or her to discuss this with staff. However, the Trust has a responsibility to ensure the safety of **all** patients at **all** times and to be aware of their whereabouts regardless of their legal status.

A patient detained under the Mental Health (NI) Order (1986) can only be given leave outside a hospital premises with the authorisation of a Consultant Psychiatrist.

If a Part 3 restricted patient goes AWOL, the Department of Justice (NI) must be contacted.

**The general principles within this guideline should be applied to any patient, detained or voluntary, who has been identified as being AWOL. In all such instances, a risk assessment should be carried out immediately to determine the level of risk which will in turn inform the action to be taken.**

## 1.4 DEFINITION

For the purpose of this guideline the definition of AWOL is as follows;

*'Inpatients either detained or voluntary will be defined as Absent Without Leave (AWOL), if they leave any of the Trusts Mental Health or Learning Disability facilities without the agreement or knowledge of staff or fail to return from escorted or unescorted leave'.*

## 2.0 DUTIES

### 2.1 DIRECTOR/CO-DIRECTOR OF MENTAL HEALTH/LEARNING DISABILITY RESPONSIBILITIES:-

To ensure provision and distribution of comprehensive, up-to-date policy based on Regional Guidelines.

## **2.2 MENTAL HEALTH/LEARNING DISABILITY SERVICES/OPERATIONAL MANAGER RESPONSIBILITIES:-**

To ensure the Trust Policy is consistently implemented across all inpatient units.

To ensure the Operational Policy includes the requirement to alert the Policy sponsor of any difficulties in implementing the policy.

To work with the ward sister/charge nurse in monitoring the frequency of the policy being put into action, identifying lessons learnt where appropriate and informing practice as necessary.

## **2.3 WARD SISTER/CHARGE NURSE RESPONSIBILITIES:-**

To ensure staff are conversant with and consistent in their application of the Trust Policy and clear about their individual responsibilities.

To inform the Mental Health/Learning Disability Line Manager on each occasion the policy is implemented and the outcome.

To ensure an Incident Report is completed when an absent without leave incident has occurred as per Trust policy.

To ensure all appropriate documentation is completed as per Trust Policy.

To work with the service manager in monitoring the frequency of the policy being put into action and identifying lessons learnt where appropriate and informing practice as necessary.

## **2.4 CLINICAL TEAM MEMBER RESPONSIBILITIES:-**

To ensure they are conversant with Trust Policy and any associated procedural documents;

To understand their individual role and responsibility in relation to implementation of the Trust Policy.

To work with the Ward Manager in monitoring the frequency of the policy being put into action and identifying lessons learnt where appropriate and informing practice as necessary.

### **3.0 RISK ASSESSMENT**

Assessment for the risk of a patient going AWOL should form part of the patient care pathway on admission informing their treatment and safety management plan; it should be documented appropriately in the patient's records and reviewed and discussed with them on a regular basis, as should the access and egress policies for the ward.

This information should be clearly communicated with other members of the clinical team as necessary.

The patients risk assessment and safety plan must be updated and reviewed following any incidents of absconding, taking into consideration any pre-disposing factors which may have instigated the incident. The patients care plan/safety plan should be updated accordingly in partnership with the patient.

Where appropriate, family/carers/next of kin should be informed of/included in the above conversations with the patient; to note the patient should always advise who they want to identify as next of kin/ want involved in such discussions.

### **4.0 MANAGEMENT OF PATIENTS ABSENT WITHOUT LEAVE**

- 4.1** The whereabouts of all patients' is checked and recorded as per Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland (2011) or local Learning Disability Observation Policy as appropriate.
- 4.2** If a patient fails to return from an agreed period of leave, or is noted to be absent from the ward/inpatient environment, the nurse in charge

will activate the AWOL Policy as appropriate following the AWOL procedure (Appendix 1).

- 4.3 If the patient is deemed as High Risk, whether they are detained or voluntary the PSNI should always be contacted by the nurse in charge.**
- 4.4 A voluntary patient must give their consent to be assisted to return to a ward, however the level of risk the patient presents to themselves or to others should determine whether or not assistance from the PSNI is required.**
- 4.5 The PSNI should always be notified when a detained patient is absent without leave.**
- 4.6 When contacting the PSNI, in addition to telephone communication the PSNI Reporting Form 'Patients Missing from Adult Mental Health/Learning Disability Inpatient Facilities' will be completed (Appendix 2) and emailed to the PSNI via the dedicated email address provided by the PSNI (Appendix 2). A copy of this form will be retained in the patient's notes. If a photograph is available it should be attached. (see procedure for contacting PSNI Appendix 2)**
- 4.7 If it is indicated in the patients Risk Assessment that the patient poses a risk to others, the decision how and who will inform the person(s) deemed to be at risk should be made in consultation with the PSNI.**
- 4.8 PATIENT WHO ABSCONDS WHILST ON ESCORTED LEAVE**

If a patient endeavours to abscond during a period of escorted leave with staff, staff may attempt to prevent them using de-escalation techniques if it is safe to do so.

If the patient absconds, the accompanying member of staff should inform the nurse in charge of the ward immediately. Once notified the nurse in charge will review any risk and ensure the Trust AWOL Policy and Procedure are implemented and followed as appropriate.

## **5.0 DOCUMENTATION TO BE COMPLETED**

**5.1** The nurse in charge will ensure that all documentation including the Patient Notes, Incident Form, AWOL documentation and the PSNI Missing Person Form (where appropriate) is completed.

## **5.2 COMMUNICATION**

The nurse in charge will communicate with all appropriate personnel as per Trust policy.

## **6.0 ON-GOING REVIEW OF THE SITUATION**

**6.1** The nurse in charge will ensure reviews by the MDT and others take place in a timely manner as per Trust Policy and all actions/outcomes are documented.

**6.2** Notification and communication with appropriate persons will be agreed and maintained throughout the duration of the patient being missing and until the situation is resolved, as per Trust Policy.

**6.3** All reviews and outcomes and all other appropriate documentation including AWOL documentation will be recorded in the patient's records.

**6.4** If after an appropriate period of time (determined by the clinical team) a voluntary patient who has gone AWOL has not been located, the clinical team may decide to discharge them pending the outcome of a clinical team discussion/risk assessment.

**6.5** If a Part 2 detained patient remains AWOL after expiration of their detention depending on the circumstances and risk assessment the clinical team may decide to discharge them.

**6.6** If a Part 3 detained patient remains AWOL, they are deemed unlawfully at large and staff should continue to maintain contact with the PSNI and the DOJ to ensure their safe return.

## **7.0 THE RETURN OF THE PATIENT ABSENT WITHOUT LEAVE**

### **7.1 VOLUNTARY PATIENTS**

Whilst every effort must be made to return an AWOL patient to the facility, there is no authority under the Mental Health (Northern Ireland) Order 1986 for a member of staff to return a voluntary patient to the facility against the patient's will.

If a voluntary patient refuses to return, risk and clinical judgement by the professional team will determine what appropriate actions need to take place.

### **7.2 DETAINED PATIENTS**

Article 29 of the Mental Health (NI) Order 1986 (Return and readmission of patients absent without leave) (see also Article 15) provides powers for the return of patients detained under the order. (PSNI Officers or HSC staff members may return the patient under Article 29).

### **7.3 DETAINED PATIENTS LOCATED OUTSIDE OF TRUST AREA**

If a detained patient is located outside the Trust area, arrangements will be made with the appropriate responsible Clinical Service Manager to have the patient returned as per the Trust Policy.

### **7.4 DETAINED PATIENTS LOCATED OUTSIDE OF NI**

If a detained patient is located outside of Northern Ireland they are subject to the legal requirements of the jurisdiction in which they are located. Where deemed necessary by the relevant jurisdiction that the person be further detained and returned to NI, appropriate steps should be put in place in keeping with the extant document '*Guidance on the transfer of mentally disordered patients detained under the Mental Health (NI) Order 1986 to and from Hospitals in Great Britain*' August 2011. The Transfer Co-Ordinator for the Trust in question will

liaise with the DHSSPSNI to confirm arrangements. Where the patient is a Part 3 detained patient the Transfer Co-Ordinator will liaise with the DOJ to confirm arrangements.

## **8.0 INTERVENTIONS FOLLOWING THE RETURN OF A PATIENT ABSENT WITHOUT LEAVE**

- 8.1** Inform all relevant parties as appropriate.
- 8.2** When the patient has returned to the ward, the Nurse in Charge and Medical Staff will carry out a full Physical and Mental State Assessment as per Trust Policy.
- 8.3** If the patient does not give consent to a physical examination being carried out, visual observations should be recorded only until the patient is willing to participate in a physical examination. If a Doctor has concerns about the physical health of a patient who has refused to participate in a physical examination the doctor should contact the Consultant for advice. This should be recorded in the patient's records.
- 8.4** If **out of hours** and a doctor is not present on the ward, a decision should be made by the nurse in charge whether the doctor is called immediately or the patient is referred to the medical team the following day; the nurse may contact the doctor to seek their advice.
- 8.5** A search of the patient's belongings may be necessary. The Trust policy on conducting a search should be followed.
- 8.6** If there is evidence to suggest that the patient has been the victim of a crime during the period they were missing, consideration should be given to informing the PSNI, subject to the wishes of the patient or next of kin.
- 8.7** The patient's risk assessment and safety plan will be reviewed.

- 8.8** The reason for the AWOL should be discussed with the patient emphasising that communicating and negotiating intentions to leave the ward is an essential part of the patient taking responsibility for their input into the treatment process.
- 8.9** Discussion with the patient in relation to implementation of strategies to prevent a re-occurrence should take place and be recorded. Relatives/next of kin/carers can be included in this discussion as appropriate. The patients care plan should be updated as appropriate.
- 8.10** A Multi-disciplinary team review should be convened following the incident.
- 8.11** In the event of a patient returning **out of hours**, it will be at the discretion of the Nurse in charge of the ward whether to inform the Senior Manager/Manager on call immediately or the Duty Manager the next day as per Trust Policy.

## **9.0 RECORDS**

Records must be retained in accordance with the Trusts Data Protection Policies and Procedures.

## **10.0 MONITORING COMPLIANCE**

- 10.1** Mental Health/Learning Disability Service Managers will have the responsibility to measure, monitor and evaluate compliance with the guidance and relevant local policy including taking an overview of the frequency of instigation of the policy.
- 10.2** Identification of trends will be part of the monitoring process; if differential patterns emerge this will be explored further and **Lessons Learnt** will be reflected in practice going forward with policies updated as appropriate.



## **11.0 DISSEMINATION & IMPLEMENTATION OF THE GUIDELINES**

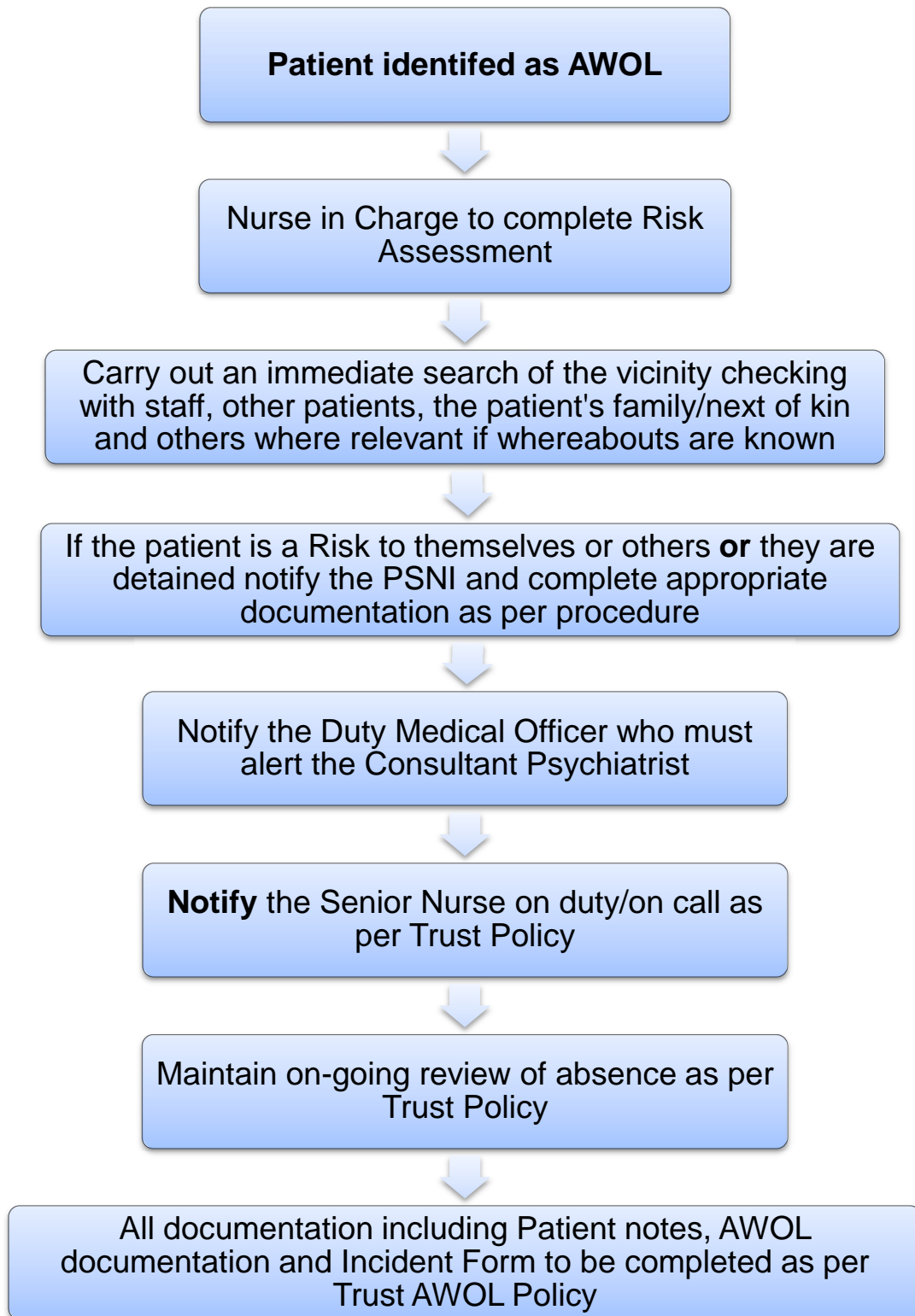
**11.1** The guidelines will be circulated electronically to all Directors of Mental Health, Mental Health/Learning Disability Service Managers and will be discussed at the Mental Health/Learning Disability Service Manager's meeting. The document will be available on the intranet for all staff and services.

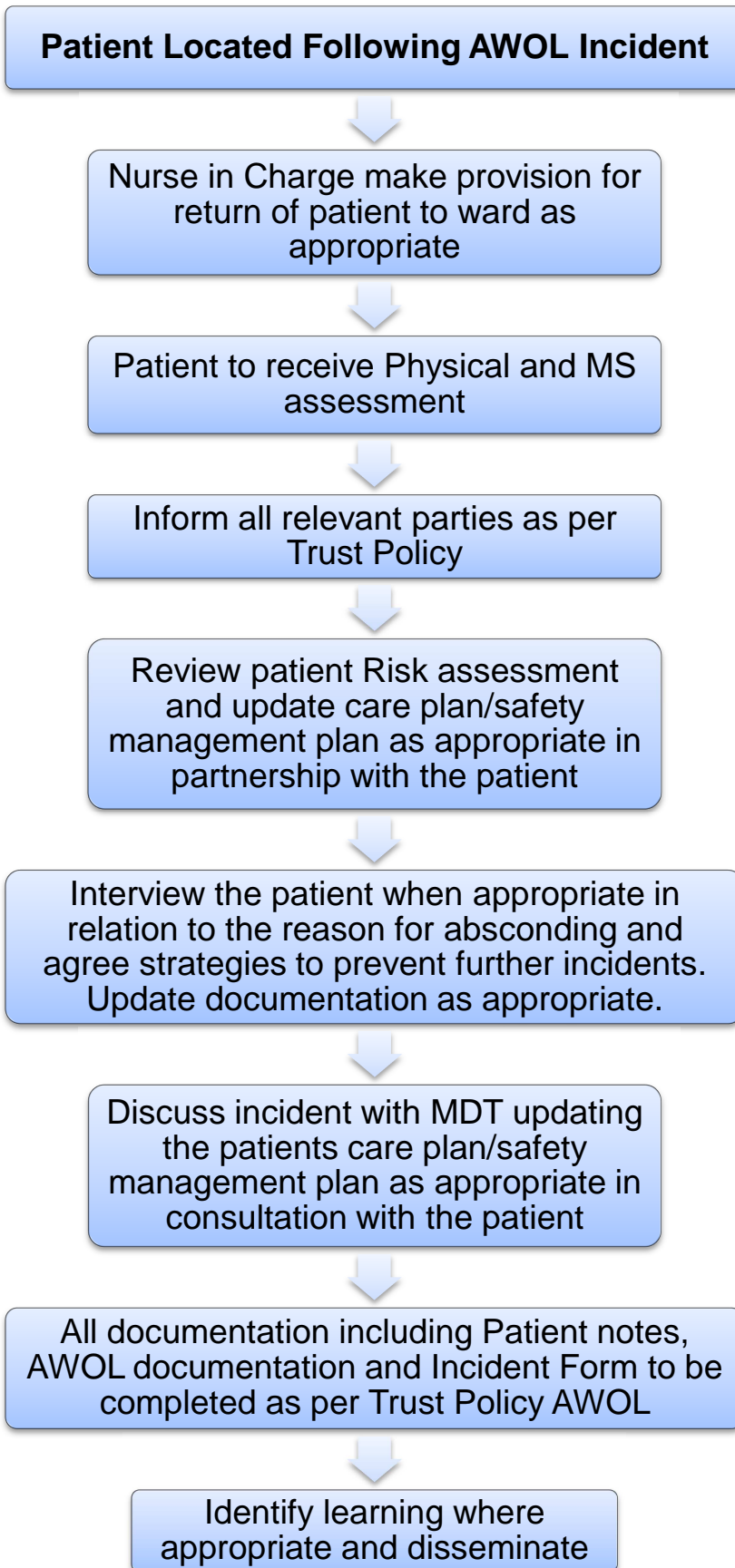
## **12.0 DOCUMENT CONTROL INCLUDING ARCHIVE ARRANGEMENTS**

This document will be stored and archived in accordance with the Trust wide policy for the development and management of procedural documents.

## Appendix 1:

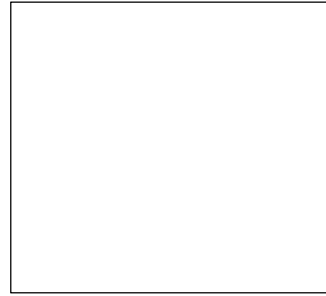
### AWOL: Procedure Flow Charts





**Appendix 2**

Keeping People Safe



Patient photograph (if available)

**PSNI Reporting Form: Patients Missing from Adult Mental Health/Learning Disability Inpatient Facilities**

PSNI Incident reference Number. \_\_\_\_\_ (provided by PSNI)

PSNI Call Handler Name \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender \_\_\_\_\_

Date of Admission: \_\_\_ / \_\_\_ / \_\_\_ Place of Admission: \_\_\_\_\_

Unit Telephone No: \_\_\_\_\_

Patient's Home Address: \_\_\_\_\_

Patient's Home Telephone Number: \_\_\_\_\_ Mobile: \_\_\_\_\_

Next of Kin/Nearest Relative/Carer \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Mobile: \_\_\_\_\_

**Mental Health Order (1986) Status:** Voluntary:  Part 2 Detained:  Part 3 Detained: (Restricted):

Part 3 Detained (Un Restricted):  Other: \_\_\_\_\_

**Description of Patient**

Complexion: \_\_\_\_\_ Colour of Hair: \_\_\_\_\_ Hair Style: \_\_\_\_\_ Eyes: \_\_\_\_\_ Height: \_\_\_\_\_

Build: \_\_\_\_\_

Any special physical characteristics/identifying factors: e.g. wearing spectacles, noticeable marks or scars, tattoos, jewellery, facial hair etc.: \_\_\_\_\_

Description of Clothing: \_\_\_\_\_

**Circumstances under which absconded**

Time Last seen \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_ Location \_\_\_\_\_

Name/Designation of person who last saw the patient \_\_\_\_\_

Has the patient any other person in the locality to whom he/she may have gone: **Yes**  **No**

If Yes: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Mobile: \_\_\_\_\_

Absconded; from ward  while on escorted leave  while on Unescorted ground leave  failed to return from leave  Other \_\_\_\_\_

Is this the first time the patient/client has absconded? Yes  No

If no provide detail: \_\_\_\_\_

Has the surrounding area been searched? Yes  No

Comment \_\_\_\_\_

**Identified Risks**

**(The factors highlighted are to assist staff in assessing the level of risk to the missing person/others; it is an aid and is not to be used as a replacement for professional judgement nor is it intended to dictate the lines of enquiry to be followed.)**

Risk Factors	Yes	No
Does the date/time/circumstances of the disappearance raise concern?		
Has the patient/client any physical condition/medical issues that may cause concern e.g. Diabetic, Respiratory problems, Epilepsy		
Does the patient/client need urgent medication		
Signs of abnormal behaviour		
Involved in violent incident or confrontation immediately prior to disappearance		
Family/personal problems		
Likelihood of Self Harm		
Likely to be violent to others		
Is there anyone in particular the patient/client may wish to harm		
Drug/Alcohol dependency		
Previous disappearance(s): suffered or exposed to harm while missing		
Vulnerable Adult		
Other factors deemed significant		

**What are the immediate concerns?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Designation** \_\_\_\_\_ **Date** \_\_\_ / \_\_\_ / \_\_\_ **Time** \_\_\_\_\_

**Regional Procedure: Communicating with the PSNI Re Patients Missing from Adult Mental Health/Learning Disability Inpatient Facilities:**

1. Phone 101 and report the person as missing; at the time of phoning ensure that the PSNI Reporting Form; **'Patients Missing from Mental Health/Learning Disability Inpatient Facilities'** is complete and all actions that can be taken have been taken.
2. The Call Handler will request full details of the referrer including their name and position as well as a verbal transfer of key information in relation to the patient and the circumstances of the incident; this will enable the Call Handler to enter the correct detail into the Command and Control system to allow for the assessment of risk and deployment of resources.
3. The Call Handler will provide the referrer with their name and the incident reference number both of which will be recorded by the referrer at the top of the PSNI Reporting Form; **'Patients Missing from Mental Health/Learning Disability Inpatient Facilities'**.
4. Trust staff will then Email the **'Patients Missing from Mental Health/Learning Disability Inpatient Facilities'** form to the below dedicated unique Email address ensuring that the Incident reference number is included in the body of the Email.
5. CMSU staff will forward the Email to the appropriate Policing District.

Please Email the **'Patients Missing from Mental Health/Learning Disability Inpatient Facilities'** form to the following **dedicated unique** Email address **for the reporting of Missing Persons form Adult Mental Health/Learning Disability Inpatient Facilities only (no other enquiries etc are to be communicated via this email address)**; no other body other than HSC Trusts should use this address:

[MentalHealthMisper@psni.pnn.police.uk](mailto:MentalHealthMisper@psni.pnn.police.uk)

**Appendix 3**

**PATIENT ABSENT WITHOUT LEAVE INFORMATION REPORT: PART 1**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Health and Care No: \_\_\_\_\_

Date of Incident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ : Voluntary:  Detained:  Other: \_\_\_\_\_

AWOL Risk as Recorded on Admission: \_\_\_\_\_

Responsible Consultant: \_\_\_\_\_

**Action Taken by Nurse in Charge**

Action	Yes	No	Date/Time	Name of Contact as appropriate	Comment as appropriate
Ward searched					
Hospital buildings searched					
Grounds searched					
Security made aware (if applicable)					
Senior Nurse on duty informed					
Relatives/NOK informed					
Medical officer informed					
Consultant informed					
PSNI informed where Risk identified					
Incident form commenced					
GP contacted (if appropriate)					
Other members of MDT as appropriate					
Department of Justice informed as appropriate					
Emergency Department alerted					
Crisis Response Team alerted					
Other					

Nurse in Charge/Team Manager/Unit Manager: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**To note some of the above actions may take place simultaneously**

**PATIENT ABSENT WITHOUT LEAVE INFORMATION REPORT: PART 2**

**Further Action Taken (If Required)**

Date \_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_\_ Review /Summary of Action Taken to Date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Multi-disciplinary meeting held: Yes  No  Date: \_\_\_/\_\_\_/\_\_\_

Attendees	Outcome/Roles and Responsibilities Identified

Date \_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_\_ Review /Summary of Action Taken to Date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Multi-disciplinary meeting held: Yes  No  Date: \_\_\_/\_\_\_/\_\_\_

Attendees	Outcome/Roles and Responsibilities Identified

Date \_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_\_ Review /Summary of Action Taken to Date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Multi-disciplinary meeting held: Yes  No  Date: \_\_\_/\_\_\_/\_\_\_

Attendees	Outcome/Roles and Responsibilities Identified



**PATIENT ABSENT WITHOUT LEAVE INFORMATION REPORT: PART 3**

**Daily Record of Communication with relevant Parties as Appropriate (note all listed parties may not require daily communication)**

Day 1	Date:	Family: <input type="checkbox"/> Medical: <input type="checkbox"/> Carers: <input type="checkbox"/> PSNI: <input type="checkbox"/> Others:
Day 2	Date:	Family: <input type="checkbox"/> Medical: <input type="checkbox"/> Carers: <input type="checkbox"/> PSNI: <input type="checkbox"/> Others:
Day 3	Date:	Family: <input type="checkbox"/> Medical: <input type="checkbox"/> Carers: <input type="checkbox"/> PSNI: <input type="checkbox"/> Others:
Day 4	Date:	Family: <input type="checkbox"/> Medical: <input type="checkbox"/> Carers: <input type="checkbox"/> PSNI: <input type="checkbox"/> Others:
Day 5	Date:	Family: <input type="checkbox"/> Medical: <input type="checkbox"/> Carers: <input type="checkbox"/> PSNI: <input type="checkbox"/> Others:
Day 6	Date:	Family: <input type="checkbox"/> Medical: <input type="checkbox"/> Carers: <input type="checkbox"/> PSNI: <input type="checkbox"/> Others:
Day 7	Date:	Family: <input type="checkbox"/> Medical: <input type="checkbox"/> Carers: <input type="checkbox"/> PSNI: <input type="checkbox"/> Others:
Day 8	Date:	Family: <input type="checkbox"/> Medical: <input type="checkbox"/> Carers: <input type="checkbox"/> PSNI: <input type="checkbox"/> Others:

Daily update report given to Senior Manager and RMO (as appropriate): Yes  No

**PATIENT ABSENT WITHOUT LEAVE INFORMATION REPORT: PART 4**

**Details of Patient's Return/Discovery and Post Incident Review**

Patient Name: \_\_\_\_\_ Health and Care Number: \_\_\_\_\_

Location and circumstances under which the patient was discovered including their reason for absconding:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date & Time Located; \_\_\_\_\_ By Whom (Name & Designation): \_\_\_\_\_

Agreed to return to Unit voluntarily: Yes  No  If no provide detail: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Date & Time Returned to unit; \_\_\_\_\_ By Whom (Name & Designation); \_\_\_\_\_

**Personnel informed of patient's return to ward (as appropriate)**

Designation	Date	Time	Staff Signature

Patient searched: Yes  No  If yes specify any dangerous items or alcohol/drugs found

\_\_\_\_\_

Did the patient cause or come to any harm during AWOL Yes  No

If yes specify

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there evidence to suggest that the patient has been the victim of or a crime or involved in a crime during the period they were missing: Yes  No

If yes specify \_\_\_\_\_

\_\_\_\_\_

If 'yes', consideration should be given to informing the PSN subject to the wishes of the patient or next of kin.

Did the patient use or obtain drugs: Yes  No  if yes specify

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Did the patient use or obtain alcohol: Yes  No  if yes specify

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Patient examined by Medical Officer: Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_

Outcome of Assessment:

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Joint Risk Assessment/Review carried out: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Risk Status \_\_\_\_\_

Signature of MO: \_\_\_\_\_ Signature of Nurse-in-Charge: \_\_\_\_\_

Outcome of MDT discussion post incident:

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Summary of patient Interview:

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Action agreed with patient to help prevent a recurrence of AWOL: \_\_\_\_\_

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Care Plan Updated: Yes  No  Comment

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Signed \_\_\_\_\_ Designation \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Copy of this completed form to be forwarded to the relevant Head of Service as appropriate**